World Health Organization

EXECUTIVE BOARD
144th session

Extracts from document WHA71/2018/REC/1 for consideration by the Executive Board at its 144th session[1]

[1] The present document is made available in order to assist the Executive Board in its deliberations. The final version of document WHA71/2018/REC/1 will be made available in due course on the Governance website at http://apps.who.int/gb/or/.

RESOLUTIONS

WHA71.1 Thirteenth General Programme of Work, 2019–2023

The Seventy-first World Health Assembly,

Having considered the draft thirteenth general programme of work, 2019−2023,[1] and welcoming its ambitious vision as expressed by the aspirational "triple billion" goals;

Noting that approval of the Thirteenth General Programme of Work, 2019–2023 does not imply approval of the financial estimate contained in document EB142/3 Add.2,

1. APPROVES the Thirteenth General Programme of Work, 2019−2023;

2. URGES Member States to support work towards achievement of the vision of the Thirteenth General Programme of Work, 2019−2023;

3. REQUESTS the Director-General:

(1) to use the Thirteenth General Programme of Work as the basis for the strategic direction of planning, monitoring and evaluation of WHO's work during the period 2019–2023, and to develop programme budgets in consultation with Member States, based on a realistic assessment of income and WHO's capacity;

(2) to take into consideration the changing state of global health in implementing the Thirteenth General Programme of Work, and to keep Member States informed of progress with implementation through regular updates to the governing bodies;

(3) to provide guidance and support to regional and country offices on the implementation of the Thirteenth General Programme of Work, taking into account different contexts;

(4) to provide a report to the Seventy-fifth World Health Assembly to inform potential extension to 2025 of the Thirteenth General Programme of Work in order to align with the wider United Nations planning cycle.

(Sixth plenary meeting, 25 May 2018 –
Committee A, first report)

[1] Document A71/4.

WHA71.2 Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018[1]

The Seventy-first World Health Assembly,

Having considered the reports on the Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018;[2]

Having recognized that the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases[3] has catalysed action and retains great potential for engendering progress towards Sustainable Development Goal target 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being);[4]

Noting with concern that, according to WHO, each year, 15 million people between the ages of 30 and 69 years die from a noncommunicable disease and that the current levels of decline in the risk of dying prematurely from noncommunicable diseases are insufficient to attain Sustainable Development Goal target 3.4 by 2030;

Welcoming the convening of the WHO Global Conference on Non-communicable Diseases,[5] which was organized by Uruguay and WHO, co-chaired by Finland, the Russian Federation and Uruguay, from 18 to 20 October 2017 in Montevideo;

Welcoming also the convening of the WHO Global Dialogue on Partnerships for Sustainable Financing of Noncommunicable Disease (NCD) Prevention and Control, hosted by the Government of Denmark and WHO from 9 to 11 April 2018 in Copenhagen, recognizing the need to prioritize tackling noncommunicable diseases as an essential pillar of sustainable development and an integral part of countries' efforts towards universal health coverage;

Recalling the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development, adopted at the 9th Global Conference on Health Promotion, held in China from 21 to 24 November 2016;

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Documents A71/14 and A71/14 Add.1.

[3] United Nations General Assembly resolution 66/2.

[4] United Nations General Assembly resolution 70/1.

[5] WHO Global Conference on Noncommunicable diseases: Enhancing policy coherence between different spheres of policy making that have a bearing on attaining SDG target 3.4 on NCDs by 2030. Geneva; World Health Organization: 2018 (http://www.who.int/nmh/events/2017/montevideo/about/en/, accessed 18 May 2018).

Taking note that the Director-General has established a WHO Independent High-level Commission on Noncommunicable Diseases[1] and a WHO Civil Society Working Group on the third High-level Meeting of the General Assembly on NCDs;[2]

Recalling United Nations General Assembly resolution 72/274 (2018) on the scope, modalities, format and organization of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases,

1. WELCOMES the outcome document of the WHO Global Conference on the Prevention and Control of Non-communicable Diseases entitled "Montevideo roadmap (2018–2030) on the prevention and control of Noncommunicable Diseases as a sustainable development priority",[3,4] as a contribution to the preparatory process leading to the third High-level Meeting;

2. URGES Member States:[5]

(1) to continue to step up efforts on the prevention and control of noncommunicable diseases in order to attain Sustainable Development Goal target 3.4 by 2030;

(2) to actively engage in the preparations at national, regional and global levels for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018;

(3) to be represented at the level of Heads of State and Government at the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and to call for action through a concise, action-oriented outcome document;

3. REQUESTS the Director-General:

(1) to continue to support Member States, in coordination with United Nations specialized agencies, funds and programmes as well as other stakeholders, in their efforts to reduce by one third premature mortality from noncommunicable diseases through prevention and control, and to promote mental health and well-being, including by applying evidence-based multisectoral and multistakeholder approaches;

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[1] WHO Independent High-level Commission on NCDs Geneva: World Health Organization: 2018 (http://www.who.int/ncds/governance/high-level-commission/en/, accessed 18 May 2018).

[2] WHO Civil Society Working Group on the third High-level Meeting of the UN General Assembly on NCDs Geneva: World Health Organization: 2018 (http://www.who.int/ncds/governance/high-level-meetings/working-group-third-high-level-meeting/en/, accessed 18 May 2018).

[3] See Annex 1.

[4] Clarification Statement: http://www.who.int/conferences/global-ncd-conference/USA_statement_EOP_montevideo_roadmap.pdf?ua=1, accessed 18 May 2018.

[5] And, where applicable, regional economic integration organizations.

(2) to report to the Seventy-second World Health Assembly, through the Executive Board, on the outcomes of the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and its follow-up.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.3 Preparation for a high-level meeting of the General Assembly on ending tuberculosis[1]

The Seventy-first World Health Assembly,

Having considered the reports on the preparation for a high-level meeting of the General Assembly on ending tuberculosis;[2]

Noting with concern that tuberculosis remains the leading infectious disease killer in the world today, responsible for an estimated 1.3 million deaths and an additional 374 000 deaths among people living with HIV/AIDS in 2016, and that the epidemic, including drug-resistant tuberculosis, poses a serious threat to health security and is a priority in the response to antimicrobial resistance;

Reaffirming resolution WHA67.1 (2014) adopting the global strategy and targets for tuberculosis prevention, care and control after 2015, subsequently known as the End TB Strategy; and resolution WHA68.7 (2015) adopting the global action plan on antimicrobial resistance; as well as recalling General Assembly resolution 71/3 (2016) "Political Declaration of the High-Level Meeting of the General Assembly on Antimicrobial Resistance";

Recalling General Assembly resolution 70/1 (2015), which adopted the 2030 Agenda for Sustainable Development and defined the Sustainable Development Goals, as well as the associated target of ending the tuberculosis epidemic by 2030;

Recalling further the report submitted to the Seventieth World Health Assembly in May 2017 on the implementation of the End TB Strategy, which concluded that global, regional and country-level actions as well as investments were falling far short of those needed and that high-level global support and regional and national commitments were required; and noting that progress is slow on all three targets of the Strategy (reducing TB incidence, reducing TB mortality, and eliminating catastrophic costs among TB patients and their households);[3]

Recognizing that to achieve the tuberculosis targets and milestones of the Sustainable Development Goals and of the End TB Strategy, care and prevention-related actions should be reinforced, paying particular attention to vulnerable groups, taking into account national contexts and circumstances, in the context of each country's path towards achieving universal health coverage and taking into account social, economic and environmental determinants and consequences of tuberculosis;

Welcoming the decision contained in General Assembly resolution 71/159 (2016), to hold a high-level meeting on the fight against tuberculosis in 2018;

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Documents A71/15, A71/16 and A71/16 Add.1.

[3] Document A70/38, section E.

Welcoming also the first WHO global ministerial conference on "Ending TB in the Sustainable Development Era: A Multisectoral Response", organized jointly with the Government of the Russian Federation and held in Moscow on 16 and 17 November 2017, and the resulting Moscow Declaration to End TB,[1] with commitments and calls to action regarding, notably: advancing the response to tuberculosis within the Sustainable Development Agenda; ensuring sufficient and sustainable financing; pursuing science, research and innovation; developing a multisectoral accountability framework; and, acting immediately to prepare for the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis;

Noting the commitment made in the Moscow Declaration to End TB to support the development of the multisectoral accountability framework, and recalling in this regard resolution EB142.R3 (2018);

Welcoming the Secretariat's report on a draft multisectoral accountability framework to accelerate progress to end tuberculosis,[2]

1. URGES Member States:[3]

(1) to support preparation for the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis, including enabling high-level participation; and

(2) to pursue the implementation of all the commitments called for in the Moscow Declaration to End TB,[1] which will contribute to reaching the targets of the End TB Strategy and the Sustainable Development Goals target to end the tuberculosis epidemic;

2. CALLS UPON all international, regional and national partners, as appropriate, to pursue the actions called for in the Moscow Declaration to End TB and invite those who have not yet endorsed it to add their support;

3. REQUESTS the Director-General:

(1) to continue to support the United Nations Secretary-General and the General Assembly, upon request, in the preparation of the high-level meeting of the General Assembly in 2018 on the fight against tuberculosis;

(2) to support, together with all relevant stakeholders, the implementation of the Moscow Declaration to End TB as a direct contribution to the success of the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis, and to advance tuberculosis prevention and care and the specific actions requested of WHO in the Moscow Declaration, including actions: to strengthen health systems towards achieving universal health coverage, including for tuberculosis prevention and care; to urgently support high multidrug-resistant tuberculosis (MDR-TB) burden countries in their national emergency response and to address MDR-TB as a major threat to public health security by supporting implementation of the global action plan on antimicrobial resistance, including tuberculosis-specific actions in all countries;

[1] See Annex 2.

[2] Documents A71/16 and A71/16 Add.1.

[3] And, where applicable, regional economic integration organizations.

(3) to continue to provide strategic and technical leadership, assistance, advice and support to Member States, as well as working with international institutions and all other relevant stakeholders, towards sufficient and sustainable financing;

(4) to develop a global strategy for tuberculosis research and innovation, taking into consideration both ongoing and new efforts, and to make further progress in enhancing cooperation and coordination in respect of tuberculosis research and development, considering where possible drawing on relevant existing research networks and global initiatives;

(5) to continue to develop, in consultation with Member States, the draft multisectoral accountability framework, working in close collaboration with all relevant international, regional and national partners as recommended in the Moscow Declaration to End TB (2017),[1] and to provide technical support to Member States and partners, as appropriate, including for national adaptation and use of the draft multisectoral accountability framework to accelerate progress to end tuberculosis, taking into account national context, laws, regulations and circumstances, in order to enable the monitoring, reporting, review and actions needed to accelerate progress to end tuberculosis, both globally and nationally, leaving no one behind, through an independent, constructive and positive approach, especially in the highest burden countries, and the independent review of progress achieved by those countries;

(6) to present the draft multisectoral accountability framework to accelerate progress to end tuberculosis at the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis;

(7) to report to the Seventy-second World Health Assembly on the implementation of this resolution.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.4 Cholera prevention and control[2]

The Seventy-first World Health Assembly,

Recalling resolution WHA64.15 (2011) on cholera: mechanism for control and prevention, which led to the revitalization of the Global Task Force on Cholera Control to support Member States to reduce the public health, social and economic consequences of cholera by strengthening WHO's work in this area, and improving collaboration and coordination among stakeholders;

Recognizing the report by the Director-General on WHO's work in health emergencies[3] and the Global Task Force on Cholera Control's recently launched strategy, Ending Cholera: A Global Roadmap to 2030,[4] which have highlighted that large-scale outbreaks of cholera continue to cause significant morbidity and mortality among vulnerable populations in both emergency and endemic settings; and that, with an estimated disease burden of 2.9 million cases and 95 000 deaths every year worldwide, the

[1] See Annex 2.

[2] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[3] Document A71/6.

[4] Ending cholera: a global roadmap to 2030 (http://www.who.int/cholera/publications/global-roadmap.pdf?ua=1, accessed 21 May 2018).

disease still affects at least 47 countries around the globe, with a potential to spread where water, sanitation and hygiene conditions are inadequate;

Acknowledging that the prevention and control of cholera require a coordinated and multisectoral approach that includes access to appropriate health care, early case management, access to safe water, sanitation, education, health literacy and improved hygiene behaviours, with adjunct use of oral cholera vaccines, strengthened surveillance and information sharing, strengthened laboratory capacity and community involvement, and action on the social determinants of health;

Acknowledging also that cholera control is both a matter of emergency response in the case of outbreaks, and a matter of development when the disease is endemic in high-risk contexts, such as in camps for refugees and internally displaced people;

Affirming that progress towards the 2030 Agenda for Sustainable Development including commitment to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 6 (Ensure availability and sustainable management of water and sanitation for all); and Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable), would reduce the prevalence and spread of cholera, along with other diarrhoeal diseases and enteric infections;

Recalling that all States Parties must comply with the International Health Regulations (2005);

Acknowledging that cholera, as a disease of epidemic potential, has to be recognized in itself and reported separately from other diarrhoeal diseases, within national surveillance systems, as not doing so hampers effective control measures,

1. URGES Member States:[1]

(1) to foster the identification by governments of cholera epidemics and to elevate cholera as a State priority in affected countries through its inclusion in national policies and plans, either as a stand-alone plan, or embedded within broader diarrhoeal disease control initiatives or within national health, health security, water, sanitation and hygiene, development and Sustainable Development Goal implementation plans, where relevant, and plans of national disaster and/or emergency management agencies;

(2) to develop and implement, in affected countries, a multisectoral package of selected effective prevention and control measures, including long-term water, sanitation and hygiene services, access to appropriate health care, access to safe water, sanitation and improved hygiene behaviours, as well as infrastructure development along with associated capacity-building activities for operations, maintenance and repairs and sustainable financing models adapted to the local transmission pattern for long-term control or elimination;

(3) to ensure that national policies and plans regarding the prevention and management of cholera comprise all areas with high-risk of cholera transmission;

(4) to establish national multisectoral cholera and acute diarrhoea prevention and surveillance mechanisms in affected countries to coordinate the implementation of the control or elimination plan, ensuring representation of the different ministries, agencies, partners and communities involved in cholera control efforts;

[1] And, where applicable, regional economic integration organizations.

(5) to strengthen capacity for: preparedness in compliance with the International Health Regulations (2005), early detection and treatment, laboratory confirmation, case management and immediate and effective response to outbreaks in order to reduce the public health, social and economic impact;

(6) to strengthen surveillance and early reporting of cholera in line with the International Health Regulations (2005), and build capacity for data collection and analysis, including information on critical determinants including water and sanitation coverage;

(7) to strengthen community involvement, social mobilization in cholera prevention, early detection, household water treatment and storage, and other related water, sanitation and hygiene response activities;

(8) to support, including through international cooperation, research for better prevention and control, including research for improved vaccines and better rapid diagnostics and treatment; and to support monitoring of antimicrobial resistance;

(9) to refrain from implementing health measures that are more restrictive of international traffic and more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection, in line with the International Health Regulations (2005);

(10) to establish national targets, when applicable, and make financial and political commitments to cholera control with national Sustainable Development Goal implementation plans;

2. REQUESTS the Director-General:

(1) to strengthen surveillance and reporting of cholera in line with the International Health Regulations (2005) and to further reinforce advocacy, strategic leadership and coordination with partners at all levels via the Global Task Force on Cholera Control secretariat and working groups, including by providing technical support and operational guidance to countries for cholera prevention and control;

(2) to increase capacity to support countries to scale up their ability to implement and monitor multisectoral, integrated interventions for long-term cholera prevention, control and elimination; interventions for preparedness and response to cholera epidemics in accordance with the global initiative of Ending Cholera: A Global Roadmap to 2030 and aligned with national plans to encourage reporting, monitor progress and disease burden in order to inform country and global strategies; and interventions for control or elimination;

(3) to support countries, upon request, in the assessment of cholera risk factors and capacity for multisectoral engagement within existing technical resources;

(4) to continue leading the management of the oral cholera vaccine stockpile to enable a sufficient global supply, including the support to and monitoring and evaluation of oral cholera vaccine use, and where appropriate vaccine campaigns, in cooperation with relevant organizations and partners, including UNICEF and Gavi, the Vaccine Alliance;

(5) to monitor and support long-term cholera prevention and control and elimination programmes at country and regional levels;

(6) to develop and promote an outcome-oriented research and evaluation agenda for cholera, targeted to address important knowledge gaps, to the improvement of implementation of existing interventions, including for water sanitation and hygiene, and to the development of improved vaccines for better and more durable prevention and outbreak control covering all aspects of cholera control;

(7) to raise the profile of cholera at the highest levels on the global public health agenda, and to strengthen coordination and engagement of multiple sectors, particularly water, sanitation and hygiene, and other non-health sectors such as finance and infrastructure development;

(8) to report to the Seventy-third World Health Assembly, through the Executive Board at its 146th session, on the global cholera situation and evaluate efforts made in cholera prevention and control.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.5 Addressing the burden of snakebite envenoming[1]

The Seventy-first World Health Assembly,

Having considered the report on global snakebite burden;[2]

Deeply concerned that snakebite envenoming[3] kills an estimated 81 000–138 000 men, women and children a year worldwide and causes physical and psychological disability in four or five times that figure;

Noting that the individuals affected by snakebite are overwhelmingly members of impoverished agricultural and herding communities, the great proportion of whom are 10–40 years of age;

Concerned that several factors, including poor prevention, health worker training, diagnosis and treatment of cases of snakebite envenoming and inadequacy of available tools for prevention, diagnosis and treatment of the disease, impede further progress in addressing snakebite envenoming;

Recognizing that snakebite envenoming causes disproportionate suffering, but has to date been largely overlooked by the global health community even though it can induce catastrophic health expenditure and exacerbate poverty;

Recognizing further that snakebite envenoming has been categorized by WHO as a high priority neglected tropical disease,[4] following the recommendation of WHO's Strategic and Technical Advisory Group for Neglected Tropical Diseases at its 10th meeting (Geneva, 29 and 30 March 2017),[5] in response to the urgent need to implement effective control strategies, tools and interventions;

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document A71/17.

[3] Snakebite envenoming is the disease resulting from the pathological and pathophysiological alterations induced by the deleterious action of venom injected in the body as a consequence of snakebite.

[4] See http://www.who.int/snakebites/resources/s40409-017-0127-6/en/ (accessed 8 December 2017).

[5] See http://www.who.int/neglected_diseases/NTD_STAG_report_2017.pdf?ua=1 (accessed 24 May 2018).

Recognizing also the lack of statistics and accurate information and the need to further improve data on the epidemiology of snakebite envenoming for a better understanding of the disease and its control;

Aware that early diagnosis and treatment are essential for reducing the morbidity, disability and mortality that snakebite envenoming can cause;

Noting with satisfaction the progress made by some Member States with regard to research into snakebite envenoming and improved case management;

Acknowledging the urgent need to improve access to safe, effective and affordable treatments in all regions of the world where snakebite envenoming is endemic;

Recognizing the work of WHO towards developing guidelines for the diagnosis and management of snakebite envenoming and for the production, control and regulation of antivenoms, and the need to make these available to all regions of the world;

Mindful that achievement of the Sustainable Development Goals of the 2030 Agenda for Sustainable Development, particularly those concerning poverty, hunger, health and education, may be hampered by the negative impact of neglected diseases of the poor, including snakebite envenoming,

1. URGES Member States:[1]

(1) to assess the burden of snakebite envenoming and, where necessary, establish and/or strengthen surveillance, prevention, treatment and rehabilitation programmes;

(2) to improve the availability, accessibility and affordability of antivenoms to populations at risk, and develop mechanisms to ensure that additional costs related to treatment and rehabilitation after snakebite envenoming are affordable for all;

(3) to promote the transfer of knowledge and technology between Member States in order to improve the global availability of antivenoms and the effective management of cases;

(4) to integrate, where possible and appropriate, efforts to control snakebite envenoming with other relevant disease-control activities;

(5) to improve access to specific treatment and rehabilitation services for the individuals affected by snakebite envenoming, by mobilizing national resources;

(6) to provide training to relevant health workers on the diagnosis and management of snakebite envenoming, with particular emphasis in regions of high incidence;

(7) to intensify and support research on snakebite envenoming, particularly in order to develop new tools to diagnose, treat, prevent and measure the burden of the disease;

(8) to promote community awareness of snakebite envenoming, through culturally contextualized public campaigns, in support of early treatment and prevention, and intensify community participation in awareness and prevention efforts;

[1] And, where applicable, regional economic integration organizations.

(9) to foster cooperation and collaboration among Member States, the international community and relevant stakeholders in order to strengthen national capacities to control, prevent and treat snakebite envenoming;

2. REQUESTS the Director-General:

(1) to accelerate global efforts for, and provide coordination in, the control of snakebite envenoming, ensuring the quality and safety of antivenoms and other treatments and prioritization of high-impact interventions;

(2) to continue to offer technical support to institutions working on research into snakebite envenoming, including WHO collaborating centres, in support of improved, evidence-based disease control efforts;

(3) to foster international efforts aimed at improving the availability, accessibility and affordability of safe and effective antivenoms for all;

(4) to provide support to Member States for strengthening their capacities to improve awareness, prevention and access to treatment and reduce and control snakebite envenoming;

(5) to foster technical cooperation among Member States as a means of strengthening surveillance, treatment and rehabilitation services;

(6) to cooperate, as appropriate and in accordance with their respective mandates, with international agencies, nongovernmental organizations, foundations and research institutions, directly to provide support to Member States in which snakebite envenoming is prevalent, upon request, in order to strengthen snakebite management activities;

(7) to report on progress in implementing this resolution to the Seventy-third World Health Assembly.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.6 WHO global action plan on physical activity 2018–2030[1]

The Seventy-first World Health Assembly,

Having considered the report on physical activity for health;[2]

Concerned by the rapidly growing burden of noncommunicable diseases, mental health disorders and other mental health conditions globally, and its negative impact on health, well-being, quality of life, and socioeconomic development;

Acknowledging that increasing physical activity and reducing sedentary behaviour can prevent at least 3.2 million noncommunicable disease-related mortalities globally per year,[3] reduce related

[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document A71/18.

[3] Global Status Report on Noncommunicable Diseases 2014. Geneva: World Health Organization; 2014, page 33.

disability and morbidity and the financial burden on health systems, and increase the number of healthy life years;

Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (2011),[1] the outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases (2014),[2] the 2030 Agenda for Sustainable Development,[3] Health Assembly resolutions WHA51.18 (1998) and WHA53.17 (2000) on the prevention and control of noncommunicable diseases, WHA55.23 (2002) on diet, physical activity and health, WHA57.17 (2004) on the global strategy on diet, physical activity and health, and WHA66.10 (2013) on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which endorsed the global action plan for the prevention and control of noncommunicable diseases 2013–2020, and which adopted a voluntary global target to, by 2025, achieve a 10% relative reduction in prevalence of insufficient physical activity;

Acknowledging the Secretariat's work in providing Member States with tools, including WHO's global Noncommunicable Diseases Progress Monitor, and guidelines to promote physical activity,[4] and further acknowledging that supplementary tools and guidelines may need to be developed to support Member States to scale up their actions in increasing physical activity and reducing sedentary behaviour;

Recognizing the efforts made by Member States and all relevant stakeholders in recent years to promote physical activity and reduce sedentary behaviour as part of broader efforts to prevent and control noncommunicable diseases and improve mental health;

Recognizing also the need to further scale up actions and enable environments to facilitate physical activity and reduce sedentary behaviour throughout the life course, bearing in mind different national contexts, priorities and policy opportunities,

1. ENDORSES the global action plan on physical activity 2018–2030;[5]

2. ADOPTS the voluntary global target of a 15% relative reduction, using a baseline of 2016, in the global prevalence of physical inactivity in adolescents[6] and in adults[7] by 2030, as an extension of the existing voluntary global target of a 10% relative reduction in prevalence of insufficient physical activity by 2025;[8]

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[1] United Nations General Assembly resolution 66/2 (2011).

[2] General Assembly resolution 68/300 (2014).

[3] General Assembly resolution 70/1 (2015).

[4] Global recommendations on physical activity for health. Geneva: World Health Organization; 2010 (http://www.who.int/dietphysicalactivity/publications/9789241599979/en/, accessed 22 January 2018).

[5] See Annex 3.

[6] Insufficient physical activity among adolescents (aged 11–17 years) is defined as less than 60 minutes of moderate to vigorous intensity activity daily.

[7] Insufficient physical activity among adults (aged 18+ years) is defined as less than 150 minutes of moderate-intensity activity per week.

[8] See resolution WHA66.10.

3. URGES Member States[1] to implement the global action plan on physical activity 2018–2030, according to national contexts and priorities, and to monitor and report on progress regularly in order to improve programme performance;

4. INVITES relevant national, regional and international partners along with other relevant stakeholders, including the private sector, to implement the global action plan on physical activity 2018–2030 and contribute to the achievement of its strategic objectives, aligned with domestic plans or strategies;

5. REQUESTS the Director-General:

(1) to implement the actions for the Secretariat in the global action plan on physical activity 2018–2030, including providing the necessary support to Member States for implementation of the plan, in collaboration with other relevant partners;

(2) to finalize, in consultation with Member States and other relevant stakeholders, a monitoring and evaluation framework on the implementation of the global action plan on physical activity 2018–2030, including a recommended set of process and impact indicators, by the end of 2018, taking into account the existing monitoring framework and indicators at the global and regional levels, and to publish it on the WHO website;

(3) to produce, before the end of 2020, the first global status report on physical activity, building on the latest available evidence and international experience, including on sedentary behaviour;

(4) to incorporate reporting on progress made in implementing the global action plan on physical activity 2018–2030 in the reports to be submitted to the Health Assembly in 2021 and 2026 in accordance with the agreed reporting sequence set out in resolution WHA66.10 (2013); and to submit a final report on the global action plan on physical activity 2018–2030 to the Health Assembly in 2030;

(5) to update the global recommendations on physical activity for health 2010.

(Seventh plenary meeting, 26 May 2018 –
Committee A, second report)

WHA71.7 Digital health[2]

The Seventy-first World Health Assembly,

Having considered the report on mHealth;[3]

Recalling resolutions WHA58.28 (2005) on eHealth and WHA66.24 (2013) on eHealth standardization and interoperability;

[1] And, where applicable, regional economic integration organizations.

[2] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[3] Document A71/20.

Recognizing the potential of digital technologies to advance the Sustainable Development Goals, in particular by supporting health systems in all countries in health promotion and disease prevention, and by improving the accessibility, quality and affordability of health services;

Recognizing also that while technology and innovations can enhance health service capabilities, human interaction remains a key element to patients' well-being;

Underscoring the need to ensure that digital health solutions complement and enhance existing health service delivery models, strengthen integrated, people-centred health services and contribute to improved population health, and health equity, including gender equality, and address the lack of evidence on the impact of digital health in these respects;

Acknowledging that the transfer of technology and knowledge on mutually agreed terms, as well as technical cooperation, aligned with Sustainable Development Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development), are important in promoting digital health;

Highlighting recent progress in the development and implementation of digital health strategies, policies, legislation and programmes by Member States,[1] WHO and partner organizations;

Acknowledging the previous experience[2] of countries and organizations, the interconnectedness of digital technologies, the collection, management and evaluation of health data, the robustness of the enabling environment, in line with established good practices, while considering the sustainability of innovations, and their feasibility, scale-up and inclusivity,

1. URGES Member States:[3]

(1) to assess their use of digital technologies for health, including in health information systems at the national and subnational levels, in order to identify areas of improvement, and to prioritize, as appropriate, the development, evaluation, implementation, scale-up and greater utilization of digital technologies, as a means of promoting equitable, affordable and universal access to health for all, including the special needs of groups that are vulnerable in the context of digital health;

(2) to consider, as appropriate, how digital technologies could be integrated into existing health systems' infrastructures and regulation, to reinforce national and global health priorities by optimizing existing platforms and services, for the promotion of people-centred health and disease prevention and in order to reduce the burden on health systems;

(3) to optimize, in health systems development and reforms, the use of resources by developing health services alongside the application and use of digital technologies;

(4) to identify priority areas where normative guidance and technical assistance and advice on digital health would be beneficial, including, but not limited to, gaps in research, evidence-based standards, support to implementation and scale-up, financing and business models, content,

[1] And, where applicable, regional economic integration organizations.

[2] Programmes specified in comments from Missions included the Global Observatory for eHealth, WHO-ITU initiative on mHealth for noncommunicable diseases, the Innovation Working Group, Every Woman Every Child initiative and the WHO-ITU National eHealth Strategy Toolkit. Principles for Digital Development (WHO endorsed).

[3] And, where applicable, regional economic integration organizations.

evaluation, cost–effectiveness and sustainability, data security, ethical and legal issues, re-use and adaptation of existing digital health and other relevant tools;

(5) to work towards and support interoperability of digital technologies for health by, inter alia, promoting the use of international and open standards as an affordable, effective and easily adaptable solution;

(6) to disseminate, as appropriate, best practices and successful examples of digital health architecture, programmes, and services, in particular effective policy design and practical implementation, with the international community, including through WHO, bilateral, regional, cross-regional and global networks, digital platforms and hubs;

(7) to strengthen public health resilience and promote opportunities, as appropriate, including to improve access to, and monitoring, sharing and use of, quality data, direct citizen, health worker and government engagement, and to build capacity for rapid response to disease incidents and public health emergencies, leveraging the potential of digital information and communication technologies to enable multidirectional communications, feedback loops and data-driven "adaptive management";

(8) to build, especially through digital means, capacity for human resources for digital health, as appropriate, across both the health and technology sectors, and to communicate areas of specific need to WHO in order to receive appropriate technical assistance;

(9) to improve the digital skills of all citizens, including through working with civil society to build public trust and support for digital health solutions, and to promote the application of digital health technology in the provision of, and access to, everyday health services;

(10) to develop, as appropriate, legislation and/or data protection policies around issues such as data access, sharing, consent, security, privacy, interoperability and inclusivity consistent with international human rights obligations, and to communicate these on a voluntary basis to WHO;

(11) to develop, as appropriate, and in coordination with existing and emerging regional hubs and support mechanisms, effective partnerships with stakeholders from across all sectors in the use of digital health;

2. REQUESTS the Director-General:

(1) to develop, within existing resources, and in close consultation with Member States[1] and with inputs from relevant stakeholders as appropriate, a global strategy on digital health, identifying priority areas including where WHO should focus its efforts;

(2) to elevate the strategic capacity of WHO in digital technologies and to mainstream these in WHO's work, operations and relevant programmes, including when working with Member States;

(3) to provide technical assistance and normative guidance to Member States, on request, for scaling up the implementation of digital health – including through the development and implementation of Member States' digital health strategies, and in line with the Thirteenth

[1] And, as applicable, regional economic integration organizations.

General Programme of Work, 2019–2023, with the appropriate structure, resources, assets and capabilities, within existing resources;

(4) to ensure that WHO builds on its strengths, by developing guidance for digital health, including, but not limited to, health data protection and usage, on the basis of its existing guidelines and successful examples from global, regional and national programmes, including through the identification and promotion of best practices, such as evidence-based digital health interventions and standards;

(5) to develop a repository on regulations, evidence related to improvements and unintended effects regarding health promotion, disease prevention and access to, and quality and cost–effectiveness of, health services, and best practices relating to digital health technologies, provided by, inter alia, Member States on a voluntary basis;

(6) to monitor developments and trends of digital technologies in health systems, public health and data science, and analyse their implications for the achievement of the health-related Sustainable Development Goals;

(7) to promote WHO's collaboration with other organizations of the United Nations system and other relevant stakeholders to strengthen digital health implementation, by leveraging their capabilities;

(8) to submit a report to the Seventy-third World Health Assembly in 2020 on the progress made in implementing this resolution.

(Seventh plenary meeting, 26 May 2018 –
Committee A, third report)

WHA71.8 Improving access to assistive technology[1]

The Seventy-first World Health Assembly,

Having considered the report on improving access to assistive technology;[2]

Considering that one billion people need assistive technology and that, as the global population ages and the prevalence of noncommunicable diseases increases, this figure will rise to more than two billion by 2050;[3]

Noting that assistive technology enables and promotes the inclusion, participation and engagement of persons with disabilities, ageing populations and people with co-morbidities in the family, community and all areas of society, including the political, economic and social spheres;

Recalling that 90% of those who need assistive technology do not have access to it, and that this has a significant adverse impact on the education, livelihood, health and well-being of individuals, and on families, communities and societies;[2]

[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document A71/21.

[3] World Health Organization, World Bank. World report on disability. Geneva: World Health Organization; 2011.

Recalling also the 2030 Agenda for Sustainable Development and its ultimate aim of ensuring that "no one is left behind";

Recognizing that the inclusion of assistive technology, in line with countries' national priorities and context, into health systems is essential for realizing progress towards the targets in the Sustainable Development Goals relating to universal health coverage, inclusive and equitable quality education, inclusive and sustainable economic growth, full and productive employment and decent work for all, reducing inequality within and among countries by empowering and promoting the social, economic and political inclusion of all, making cities and human settlements inclusive, safe and sustainable, and providing universal access to safe, inclusive and accessible green and public spaces, particularly for persons with disabilities;

Recalling the United Nations Convention on the Rights of Persons with Disabilities, under which 175 Member States have committed, inter alia, to ensuring access to quality assistive technology at an affordable cost (Articles 4, 20, and 26) and to foster international cooperation (Article 32) in support of national efforts for the realization of the purpose and objectives of the Convention;

Emphasizing the need for a comprehensive, sustainable and multisectoral approach to improving access to assistive technology that fulfils the safety and quality standards established by national and international regulations, at the national and subnational levels;

Recalling resolutions WHA69.3 (2016), WHA67.7 (2014), and WHA66.4 (2013) and WHA70.13 (2017) in which, respectively, the Health Assembly calls on Member States, inter alia, to improve access to assistive technology for older people, people with disabilities and people with vision and hearing loss;

Noting the request made to the Executive Board by the WHO Regional Committee for the Eastern Mediterranean, in resolution EM/RC63/R.3 (2016) on improving access to assistive technology, to include assistive technology as an agenda item for the Health Assembly,

1. URGES Members States:[1]

(1) to develop, implement and strengthen policies and programmes, as appropriate, to improve access to assistive technology within universal health and/or social services coverage;

(2) to ensure that adequate and trained human resources for the provision and maintenance of assistive products are available at all levels of health and social service delivery;

(3) to ensure that assistive technology users and their carers have access to the most appropriate assistive products and use them safely and effectively;

(4) where appropriate, based on national needs and context, to develop a national list of priority assistive products that are affordable and cost-effective and that meet minimum quality and safety standards, drawing on WHO's priority assistive products list;

(5) to promote or invest in research, development, innovation and product design in order to make existing assistive products affordable; and to develop a new generation of products including high-end or advanced assistive technology, taking advantage of universal design and new evidence-based technologies, in partnership with academia, civil society organizations, in

[1] And, where applicable, regional economic integration organizations.

particular with persons with disabilities and older persons and their representative organizations, and the private sector, as appropriate;

(6) to encourage international and/or regional collaboration for the manufacturing, procurement and supply of priority assistive products, ensuring that these remain affordable and available across borders;

(7) to collect population-based data on health and long-term care needs, including those that may be met by assistive technology in order to develop evidence-based strategies, policies and comprehensive programmes;

(8) to invest in and promote inclusive barrier-free environments so that all people who need assistive technology can make optimum use of it, in order to live independently and safely and participate fully in all aspects of life;

(9) to promote the inclusion of priority assistive products and inclusive barrier-free environments within emergency preparedness and response programmes;

2. REQUESTS the Director-General:

(1) by 2021, to prepare a global report on effective access to assistive technology in the context of an integrated approach, based on the best available scientific evidence and international experience, with the participation of all relevant units within the Secretariat and in collaboration with all relevant stakeholders, giving consideration to the possibility of establishing an Expert Advisory Group, within existing resources, for this purpose;

(2) to provide the necessary technical and capacity-building support for Member States, aligned with national priorities, in the development of national assistive technology policies and programmes, including procurement and financing, regulation, training for health and social services, appropriate service delivery, and inclusive barrier-free environments;

(3) to provide technical and capacity-building support to countries, on request, to assess the feasibility of establishing regional or subregional manufacturing, procurement and supply networks for assistive technology and cooperation platforms;

(4) to contribute to and engage in, as appropriate, the development of minimum standards for priority assistive products and services, in order to promote their safety, quality, cost-effectiveness and appropriateness;

(5) to report on progress in the implementation of the present resolution to the Seventy-fifth World Health Assembly and thereafter to submit a report to the Health Assembly every four years until 2030.

(Seventh plenary meeting, 26 May 2018 –
Committee A, third report)

WHA71.9 Infant and young child feeding[1]

The Seventy-first World Health Assembly,

Having considered the reports on maternal, infant and young child nutrition;[2]

Recalling resolutions WHA33.32 (1980), WHA34.22 (1981), WHA35.26 (1982), WHA37.30 (1984), WHA39.28 (1986), WHA41.11 (1988), WHA43.3 (1990), WHA45.34 (1992), WHA46.7 (1993), WHA47.5 (1994), WHA49.15 (1996), WHA54.2 (2001), WHA55.25 (2002), WHA58.32 (2005), WHA59.21 (2006), WHA61.20 (2008), WHA63.23 (2010), WHA65.6 (2012) and WHA69.9 (2016) on infant and young child nutrition, appropriate feeding practices and related questions, as well as resolutions WHA68.19 (2015), WHA69.8 (2016) and United Nations General Assembly resolution 70/1 (2015);

Reaffirming the commitment made in the 2030 Agenda for Sustainable Development, including to end all forms of malnutrition by 2030;

Recalling the commitment to implement relevant international targets and action plans, including WHO's global maternal, infant and young child nutrition targets for 2025 and WHO's global action plan for the prevention and control of noncommunicable diseases 2013−2020 and the Rome Declaration on Nutrition resulting from the Second International Conference on Nutrition;

Reaffirming also that breastfeeding is critical for child survival, nutrition and development, and for maternal health;

Affirming that the protection, promotion and support of breastfeeding contributes substantially to the achievement of the Sustainable Development Goals on nutrition and health, and is a core element of quality health care;

Recognizing that appropriate, evidence-based and timely support of infant and young child feeding in emergencies saves lives, protects child nutrition, health and development, and benefits mothers and families;

Expressing concern that nearly two in every three infants under 6 months of age are not exclusively breastfed; that fewer than one in five infants are breastfed for 12 months in high-income countries; and that only two in every three children between 6 months and 2 years of age receive any breast milk in low- and middle-income countries;

Acknowledging that achievement of the WHO global target to increase to at least 50% the proportion of infants under 6 months of age who are exclusively breastfed by 2025 requires sustainable and adequate technical and financial resources, and supportive and protective policy and regulatory interventions, as well as political will, and that this needs to be part of broader efforts to strengthen health systems;

Welcoming the inclusion of support for exclusive breastfeeding in the Thirteenth General Programme of Work, 2019–2023;

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Documents A71/22 and A71/23.

Welcoming also the annual celebration of World Breastfeeding Week as an opportunity to communicate the importance of breastfeeding and advocate for the protection, promotion and support of breastfeeding;[1]

Also recognizing the ongoing implementation by WHO of the Framework of Engagement with Non-State Actors, including in nutrition programmes,

1. URGES Member States[2,3,4] in accordance with national context and international obligations:

(1) to increase investment in development, implementation and monitoring and evaluation of laws, policies and programmes aimed at protection, promotion, including education and support of breastfeeding, including through multisectoral approaches and awareness raising;

(2) to reinvigorate the Baby-friendly Hospital Initiative, including by promoting full integration of the revised Ten Steps to Successful Breastfeeding, in efforts and programmes aimed at improving quality of care in support of maternal, newborn and child health;

(3) to implement and/or strengthen national mechanisms for effective implementation of measures aimed at giving effect to the International Code of Marketing of Breast-milk Substitutes, as well as other WHO evidence-based recommendations;

(4) to promote timely and adequate complementary feeding in accordance with the guiding principles for complementary feeding of the breastfed child,[5] as well as guiding principles for feeding non-breastfed children 6–24 months of age;[6]

(5) to continue taking all necessary measures in the interest of public health to implement recommendations to end inappropriate promotion of foods for infants and young children;

(6) to take all necessary measures to ensure evidence-based and appropriate infant and young child feeding during emergencies, including through preparedness plans, capacity-building of personnel working in emergency situations, and coordination of intersectoral operations;

(7) to celebrate World Breastfeeding Week[7] as a valuable means to promote breastfeeding;

2. REQUESTS the Director-General:

(1) to provide, upon request, technical support to Member States in mobilizing resources, including financial resources, and monitoring and implementation of WHO recommendations to support infant and young child feeding, including in emergencies, and to review national

[1] http://worldbreastfeedingweek.org/, accessed 21 May 2018.

[2] And where applicable, regional economic integration organizations.

[3] Taking into account the context of federated states.

[4] Member States could take additional action to end inappropriate promotion of food for infants and young children.

[5] Guiding principles for complementary feeding of the breastfed child. Washington (DC): PAHO; 2003 (http://www.who.int/maternal_child_adolescent/documents/a85622/en/, accessed 21 May 2018).

[6] Guiding principles for feeding non-breastfed children 6-24 months of age. Geneva: World Health Organization; 2005 (http://www.who.int/maternal_child_adolescent/documents/9241593431/en/, accessed 18 May 2018).

[7] http://worldbreastfeedingweek.org/, accessed 21 May 2018.

experiences arising from this implementation and continue to update and generate evidence-based recommendations;

(2) to provide, upon request, technical support to Member States to establish, review and implement national laws, policies and programmes to support infant and young child feeding;

(3) to continue developing tools for training, monitoring and advocacy on the revised Ten Steps to Successful Breastfeeding and the Baby-friendly Hospital Initiative, in order to provide support to Member States with implementation;

(4) to support Member States in establishing nutrition targets and intermediate milestones for maternal, infant and young child nutrition indicators, consistent with the time frame for implementation of the Framework for Action, the conference outcome document of FAO and WHO's Second International Conference on Nutrition, and the United Nations Decade of Action on Nutrition (2016–2025) and the timeframe of the Sustainable Development Goals (2015–2030);

(5) to continue providing adequate technical support to Member States, upon request, in assessing national policies and programmes, and other measures, including quality data collection and analyses;

(6) to develop tools for training, monitoring, advocacy and preparedness for the implementation of the operational guidance on infant and young child feeding in emergencies, and support Member States in reviewing experiences in its adaptation, implementation and monitoring;

(7) to report to the Seventy-third World Health Assembly in 2020 on the progress made in implementing this resolution and in alignment with the reporting requested in resolution WHA69.9.

(Seventh plenary meeting, 26 May 2018 –
Committee A, fourth report)

WHA71.10 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

The Seventy-first World Health Assembly,

Having considered the report on status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears;[1]

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-first World Health Assembly;[2]

[1] Document A71/31 Rev.1.

[2] Document A71/47.

Noting that, at the time of opening of the Seventy-first World Health Assembly, the voting rights of the Central African Republic, Comoros, Gambia, Guinea-Bissau, South Sudan and Ukraine were suspended, such suspension shall continue until the arrears of the Member States concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that Cameroon, Libya, Niger and Venezuela (Bolivarian Republic of) were in arrears at the time of the opening of the Seventy-first World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether the voting privileges of those countries should be suspended – at the opening of the Seventy-second World Health Assembly in 2019,

DECIDES:

(1) that, in accordance with the statement of principles set out in resolution WHA41.7 (1988), if, by the time of the opening of the Seventy-second World Health Assembly, Cameroon, Libya, Niger and Venezuela (Bolivarian Republic of) are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;

(2) that any suspension that takes effect as set out in paragraph (1) above shall continue at the Seventy-second World Health Assembly and subsequent Health Assemblies, until the arrears of Cameroon, Libya, Niger and Venezuela (Bolivarian Republic of) have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

(3) that this decision shall be without prejudice to the right of any member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71.11 Deputy Directors-General[1]

The Seventy-first World Health Assembly,

Noting the recommendations of the Executive Board with regard to Articles I, III and IV of the Staff Regulations,[2]

1. ADOPTS the proposed amendments to Staff Regulations 1.11, 3.1 and 4.5;[3]

2. DECIDES that these amendments shall take effect from 1 January 2018.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document A71/37.

[3] See Annex 4.

WHA71.12 Salaries of staff in ungraded positions and of the Director-General[1]

The Seventy-first World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,[2]

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US$ 176 292 gross per annum, with a corresponding net salary of US$ 131 853;

2. ESTABLISHES the salary of Deputy Directors-General at US$ 194 329 gross per annum, with a corresponding net salary of US$ 143 757;

3. ESTABLISHES the salary of the Director-General at US$ 239 755 gross per annum, with a corresponding net salary of US$ 173 738;

4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2018.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71.13 Reform of the global internship programme[1]

The Seventy-first World Health Assembly,

Having considered the human resources annual reports of 2015, 2016 and 2017;[3]

Recognizing, consistent with the implementation of the 2030 Agenda for Sustainable Development and progress towards the attainment of universal health coverage, the need for effective public health leadership, resilient health systems and strong health workforce capacity;

Guided by the Thirteenth General Programme of Work, outlining the WHO's strategic vision for the period 2019–2023, which commits to, inter alia, promoting greater access to, and equity in, the internship programme;

Affirming the internship programme's goal to build future leaders in public health through professional training and capacity-building opportunities across headquarters, regional and country offices, and the valuable contributions interns make to the Organization;[4]

Recalling Member States' concerns over the persistent imbalance in geographical participation in the internship programme, due in large part to the absence of financial support for talented future health leaders and insufficient attention paid so far to geographical diversity and gender equity among interns;

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] See document A71/37.

[3] Documents A69/52, A70/45 and A71/35.

[4] The WHO e-Manual defines an intern is an individual who is at least 20 years old, enrolled in a university or equivalent institution leading to a formal qualification (graduate or postgraduate). Applicants who have already graduated may also qualify for consideration provided that they apply for an internship within six months after completion of their formal qualification. Interns do not have the status of WHO staff members and cannot represent the Organization in any official capacity.

Underscoring the commitment of all Member States towards improvements in the WHO reform process across the three levels of the Organization, including balanced geographical participation and gender equity;

Recognizing WHO's efforts and changes to improve the transparency and accessibility of the internship programme and its ambition to implement comprehensive reform,

1. DECIDES that continued improvements to the internship programme shall be achieved through:

(1) the development of a sustainable and equitable internship programme based on an internship strategy and semi-structured training curriculum for interns to maximize their training experience and reinforce the learning objectives of the programme, which are, inter alia, to build a diverse pool of future leaders in public health and provide experience in the technical and administrative programmes of WHO;

(2) the strengthening of a transparent, merit-based intern recruitment process that promotes the widest possible geographical participation and gender equity, through objective review of all intern applicants who meet the criteria;

(3) the setting of a target that by 2022, at least 50% of accepted interns on the programme originate from least developed countries and middle-income countries with the objective of achieving balanced participation among WHO regions and gender equity;

(4) the provision by the Secretariat of financial assistance, as soon as possible and no later than 2020, and where applicable, in-kind assistance, including through collaboration with host countries, for all accepted interns without sufficient existing support, at a level set for the duty station, to cover reasonably incurred travel and living expenses for the duration of the internship;

2. URGES Member States, development partners and donors to support WHO in mobilizing the resources necessary for financial sustainability and where applicable in-kind assistance for the internship programme, thereby ensuring that talented future health leaders from all Member States can equally access the programme, irrespective of economic circumstance;

3. INVITES international, regional, national and local stakeholders to engage in and support the implementation of the actions set out in this resolution;

4. REQUESTS the Director-General:

(1) to take the necessary measures and, in keeping with the aims of broader human resources policy, to operationalize the objectives of this resolution, across all three levels of the Organization, drawing from the best practices of other United Nations organizations and in line with United Nations rules, regulations and relevant resolutions;

(2) to include as part of the human resources annual report, statistics on applicants' and accepted interns' demographic data, including gender and country of origin, as well as information on progress towards the implementation of this resolution;

(3) to submit a report to the Executive Board at its 144th session in January 2019, detailing by which mechanism financial and in-kind support to accepted interns will be provided commensurate with their needs;

(4) to submit a stand-alone report to the Seventy-sixth World Health Assembly through the Executive Board in 2023, outlining the progress made in achieving the targets set out in this resolution and the future steps planned.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71.14 Rheumatic fever and rheumatic heart disease[1]

The Seventy-first World Health Assembly,

Having considered the report on rheumatic fever and rheumatic heart disease;[2]

Reaffirming resolutions: WHA66.10 (2013) on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases; WHA68.7 (2015) on global action plan on antimicrobial resistance; WHA69.2 (2016) on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health; and WHA69.25 (2016) on addressing the global shortage of medicines and vaccines, and the safety and efficacy of children's medicine; and the 2015 African Union Addis Ababa Communiqué on Eradication of Rheumatic Heart Disease in Africa;[3]

Noting with concern that rheumatic heart disease is a significant, preventable cause of morbidity and mortality for people in all WHO regions which, even with incomplete data, is known to affect at least 33 million individuals and cause over 300 000 deaths annually, especially among vulnerable and marginalized groups including children, adolescents, pregnant women and poor and indigenous populations;[4]

Recognizing that rheumatic heart disease is a preventable condition arising from acute rheumatic fever, a secondary sequela of group A beta haemolytic streptococcal pharyngitis, and that early detection and diagnosis of this form of pharyngitis, acute rheumatic fever and rheumatic heart disease, with judicious antibiotic treatment of group A beta haemolytic streptococcal pharyngitis and appropriate antibiotic prophylaxis for those who have experienced acute rheumatic fever, can substantially reduce morbidity and mortality in a cost-effective way;

Concerned by a lack of reliable access to essential medicines for the prevention and treatment of group A beta haemolytic streptococcal pharyngitis, acute rheumatic fever and rheumatic heart disease;

Recalling that global initiatives can provide much-needed leadership, awareness and momentum to "beat" rheumatic heart disease, as demonstrated by the WHO global programme for the prevention and control of rheumatic heart disease (1984–2002);

Recognizing that rheumatic heart disease is a preventable disease of poverty, that pursuit of the Sustainable Development Goals to end poverty and achieve universal health coverage is therefore

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document A71/25.

[3] Available at http://www.pascar.org/uploads/files/ADDIS_ABABA_COMMUNIQU%C3%89_ON_ERADICATION_OF_RHUEMATIC_HEART_DISEASE_IN_AFRICA_-_Submission1.pdf, accessed 30 May 2017.

[4] The Global Burden of Disease Study 2010.

critical, and that reducing barriers to effective prevention and control is consistent with the WHO Constitution and priority work areas,

1. URGES Member States:[1]

(1) to accelerate multisectoral efforts towards reducing poverty and improving socioeconomic standards by all means, tackling the known root determinants of rheumatic heart disease, including poor housing, overcrowding and reduced access to care;

(2) to estimate the burden of rheumatic heart disease, and, in the case of countries where the disease is endemic, in accordance with their national context and priorities, to implement and resource rheumatic heart disease programmes that foster multisectoral work focused on prevention, improved disease surveillance and collection and analysis of good-quality data that facilitate appropriate follow-up and contribute to a broader understanding of the global disease burden;

(3) to improve access to primary health care, including through investing in a community and primary health care workforce trained in prevention, diagnosis and evidence-based management of group A beta haemolytic streptococcal pharyngitis, acute rheumatic fever and rheumatic heart disease with its potential complications, alongside improving understanding of prevention and control of rheumatic heart disease among at-risk populations;

(4) to ensure timely, affordable and reliable access to cost-effective essential laboratory technologies and medicines for the diagnosis, prevention and treatment of acute rheumatic fever and rheumatic heart disease;

(5) to strengthen national and international cooperation to address rheumatic heart disease, including through setting global and national measures for reducing the burden of disease, utilizing and sharing best practice methodologies for prevention and control, and creating national and regional networks for specialist diagnosis and treatment, when needed;

2. INVITES relevant international stakeholders such as nongovernmental organizations, academic institutions, private sector entities and philanthropic foundations, as appropriate, to assist in driving forward global efforts for the prevention and control of rheumatic heart disease, and collaborate:

(1) to put people living with rheumatic heart disease at the centre of the prevention and control agenda, and to continue to advocate on behalf of communities at risk of, or affected by, rheumatic heart disease;

(2) to raise the profile of rheumatic heart disease and other noncommunicable diseases of children and adolescents on the global agenda, with a view to strengthening health systems in low- and middle-income countries, eradicating poverty and addressing health inequities;

(3) to facilitate timely, affordable and reliable access to existing and cost-effective new medicines and technologies for prevention and control of rheumatic heart disease by supporting research and development, including gaining a greater understanding of the pathogenesis and epidemiology of acute rheumatic fever and rheumatic heart disease, and by providing open-access resources;

[1] And, where applicable, regional economic integration organizations.

3. REQUESTS the Director-General:

(1) to reinvigorate engagement in, and lead and coordinate global efforts on, prevention and control of rheumatic heart disease, ensuring adequate resourcing, with rheumatic heart disease considered broadly across relevant WHO work areas, extending beyond the noncommunicable disease programme;

(2) to support Member States in identifying rheumatic heart disease burden and, where appropriate, in developing and implementing rheumatic heart disease programmes and strengthening health systems in order to improve disease surveillance, increase the availability and training of the community and primary health care workforce, and ensure reliable access to affordable prevention, diagnostic and treatment tools;

(3) to foster international partnerships for mobilizing resources, sharing best practice methodologies, developing and supporting a strategic research and development agenda, and facilitating access to existing and new medicines and technologies;

(4) to assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed measures, and to monitor efforts for the prevention and control of rheumatic heart disease;

(5) to report on implementation of this resolution to the Seventy-fourth World Health Assembly.

(Seventh plenary meeting, 26 May 2018 –
Committee B, third report)

WHA71.15 Multilingualism: respect for equality among the official languages[1]

The Seventy-first World Health Assembly,

Having considered the report by the Director-General;[2]

Recalling United Nations General Assembly resolution 71/328, which calls for multilingualism to be addressed in a cost-neutral practical, efficient and cost-effective manner;

Mindful that the universality of WHO is based, inter alia, on multilingualism and on respect for the parity and plurality of the official languages chosen by the Member States;

Recalling the resolutions and rules governing language arrangements at WHO, especially resolution WHA50.32 (1997) on respect for equality among the official languages, resolution WHA51.30 (1998) on method of work of the Health Assembly, which requested the Director-General to make WHO governing body documents available on the internet, and resolution EB105.R6 (2000) on the use of languages in WHO;

Convinced of the importance of respect for the diversity of cultures and the plurality of international languages for improving health policies in the world, especially in the developing

[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document A71/50.

countries, and for giving all Member States access to information and to scientific and technical cooperation;

Regretting that the various official languages and the working languages are still used unequally within WHO;

Reaffirming the need to ensure high-quality translation of documents into all official languages of the Organization;

Considering that the preparation and distribution of the essential technical information of the Organization, such as the WHO guidelines, in the six official languages is one of the fundamental conditions for equality among Member States;

Stressing the need to achieve full parity among the six official languages including on the WHO internet site,

REQUESTS the Director-General:

(1) to take into account recommendations contained in United Nations General Assembly resolution 71/328 and to work in cooperation with the United Nations Secretary-General's language services, including to develop cost-neutral approaches;

(2) to apply the rules of the Organization that establish linguistic practice within the Secretariat in a cost-neutral, practical, efficient and cost-effective manner;

(3) to ensure that all language services are given equal treatment and are provided with equally favourable working conditions and resources, with a view to achieving maximum quality of services;

(4) to promote multilingualism in the daily work of the Secretariat and encourage staff to take advantage of technical and scientific literature generated in the maximum number of languages, both official and non-official, in a cost effective-manner;

(5) to ensure that job descriptions specify the need for multilingual skills, including a working language of the Secretariat;

(6) to appoint an officer who can serve as Coordinator for Multilingualism, who will be responsible, inter alia, for supervising and supporting the overall implementation of multilingualism, and to call upon all WHO departments to fully support the work of the Coordinator in the implementation of the relevant mandates on multilingualism;

(7) to continue to improve and update in a cost-effective manner the WHO internet site in all official languages to make it more widely accessible and to develop a multilingual public communication strategy;

(8) to take the necessary steps to ensure, including through improved planning and coordination, the timely translation into all official languages of the essential technical information of the Organization and WHO guidelines, whether in written, audiovisual or digital form, making such information more widely accessible without undue delay;

(9) to develop a report on the previous practices, possible technical options and solutions, including cost-effective, innovative measures and all programme and budgetary implications, to

improve the current situation and ensure availability of the essential technical information of the Organization and WHO guidelines, whether in written, audiovisual or digital form in the six official languages, to be submitted for consideration by the Seventy-second World Health Assembly, through the Executive Board at its 144th session.

(Seventh plenary meeting, 26 May 2018 – Committee B, third report)

WHA71.16 Poliomyelitis – containment of polioviruses[1]

The Seventy-first World Health Assembly,

Having considered the report on eradication of poliomyelitis;[2]

Recalling resolution WHA65.5 (2012) on poliomyelitis: intensification of the global eradication initiative and WHA68.3 (2015) on poliomyelitis, and in which the Health Assembly urged all Member States inter alia to implement appropriate containment of all polioviruses starting with the serotype 2;

Noting the eradication of wild poliovirus type 2 globally, declared by the Global Commission for the Certification of the Eradication of Poliomyelitis in September 2015;

Acknowledging the continued progress in eradicating poliovirus types 1 and 3;

Recognizing the successful globally synchronized switch in April 2016 from the use of trivalent to bivalent oral polio vaccine, active only against poliovirus types 1 and 3;

Noting the development of the Polio Eradication and Endgame Strategic Plan 2013–2018, including objective 3 – containment and certification, considered by the Sixty-sixth World Health Assembly;[3]

Commending the work of WHO and the Global Commission for the Certification of the Eradication of Poliomyelitis in promoting the containment of all polioviruses, starting with type 2, the first serotype being eradicated;

Noting with alarm delays in implementation and certification of poliovirus containment for type 2 polioviruses planned for 2016, as well as the accidental release of wild poliovirus type 2 from a vaccine-production facility in 2017;

Underscoring the urgent need to accelerate globally activities to implement and certify containment of polioviruses;

Underlining that successful containment of all polioviruses will ensure the long-term sustainability of the eradication of poliomyelitis,

[1] See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

[2] Document A71/26.

[3] Document WHA66/2013/REC/3, summary records of the ninth meeting of Committee A, section 1.

1. URGES all Member States:[1]

(1) to fully implement all strategic approaches outlined in the Polio Eradication and Endgame Strategic Plan 2013–2018;

(2) to intensify efforts to accelerate the progress of poliovirus containment certification as outlined in national requirements[2] as well as in the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);[3]

(3) to complete inventories for type 2 polioviruses, destroy unneeded type 2 materials and to begin inventories and destruction of unneeded type 1 and 3 materials in accordance with the latest available published WHO guidance;

(4) to ensure that any confirmed event associated with a breach in poliovirus containment is immediately reported to the National IHR Focal Point;

2. URGES all Member States retaining polioviruses:

(1) to reduce to a minimum the number of facilities designated for the retention of polioviruses, prioritizing facilities performing critical national or international functions;

(2) to appoint, as soon as possible and no later than the end of 2018, a competent national authority for containment[4] that will process containment certification applications submitted by the facilities designated to store and/or handle poliovirus post-eradication and communicate its contact details to WHO by 31 March 2019;

(3) to make available to the national authority for containment all necessary resources, including technical, personnel and financial, required for the full and successful certification of implementation of appropriate poliovirus containment measures;

(4) to request facilities designated to retain poliovirus type 2 to formally engage in the Containment Certification Scheme[5] by submitting to their national authorities for containment their applications for participation, which is the first step of the global certification process, as soon as possible and no later than 31 December 2019;[4]

(5) to initiate steps for the containment for wild type 1 and 3 materials so that, by the time of global certification of eradication, all facilities retaining poliovirus meet containment requirements;

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[1] And, where applicable, regional economic integration organizations.

[2] Containment Advisory Group, see http://polioeradication.org/tools-and-library/policy-reports/advisory-reports/containment-advisory-group/ (accessed 1 March 2018).

[3] Available at http://polioeradication.org/wp-content/uploads/2016/12/GAPIII_2014.pdf (accessed 1 March 2018).

[4] As recommended at the Special Meeting of the Global Commission for the Certification of the Eradication of Poliomyelitis on Poliovirus Containment (Geneva, 23–25 October 2017); the meeting report is available at http://polioeradication.org/wp-content/uploads/2018/01/polio-global-certification-commission-report-2017-10-final-en.pdf (accessed 1 March 2018).

[5] Available at http://polioeradication.org/wp-content/uploads/2017/03/CCS_19022017-EN.pdf (accessed 26 May 2018).

(6) to prepare a national response framework for use in the event of a breach of poliovirus containment and risk of community exposure and to conduct a polio outbreak simulation exercise that covers the risk of poliovirus release from a facility;

3. REQUESTS the Director-General:

(1) to provide technical support to Member States in their efforts to implement poliovirus containment safeguards and certify that facilities retaining poliovirus meet the requirements outlined in the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);

(2) to facilitate the harmonization of certification mechanisms for the long-term sustainability of the implementation of poliovirus containment in the post-eradication era;

(3) to update all WHO's recommendations and guidance on poliovirus containment, as and when needed;

(4) to report regularly to the Executive Board and the Health Assembly on progress and on the status of global poliovirus containment, aligned with other polio reporting requirements.

(Seventh plenary meeting, 26 May 2018 –
Committee B, fourth report)

DECISIONS

WHA71(1) Composition of the Committee on Credentials

The Seventy-first World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Bahrain, El Salvador, Iceland, Jamaica, Lesotho, Mongolia, Nepal, Niger, Sao Tome and Principe, Serbia, Solomon Islands and Turkmenistan.

(First plenary meeting, 21 May 2018)

WHA71(2) Election of officers of the Seventy-first World Health Assembly

The Seventy-first World Health Assembly elected the following officers:

President: Dr Pagwesese David Parirenyatwa (Zimbabwe)

Vice-Presidents: Dr F. Duque III (the Philippines)
Ms K. Abdul Samad Abdulla (Maldives)
Dr Y. Birtanov (Kazakhstan)
Dr D. Elmi Okieh (Djibouti)
Dr R. Sánchez Cárdenas (Dominican Republic)

(First plenary meeting, 21 May 2018)

WHA71(3) Election of officers of the main committees

The Seventy-first World Health Assembly elected the following officers of the main committees:

Committee A:	**Chairman**	Mr Arun Singhal (India).
Committee B:	**Chairman**	Dr Feroz Firozuddin (Afghanistan).

(First plenary meeting, 21 May 2018)

The main committees subsequently elected the following officers:

Committee A:	**Vice-Chairmen**	Dr Søren Brostrøm (Denmark) Mrs Mónica Martínez Menduiño (Ecuador)
	Rapporteur	Dr Alain Etoundi Mballa (Cameroon)
Committee B:	**Vice-Chairmen**	Dr Stewart Jessamine (New Zealand) Professor Nicolas Méda (Burkina Faso)
	Rapporteur	Dr José Eliseo Orellana (El Salvador)

(First meetings of Committees A and B,
21 and 23 May 2018, respectively)

WHA71(4) Establishment of the General Committee

The Seventy-first World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Argentina, Barbados, Botswana, Bulgaria, China, Cuba, Fiji, France, Gabon, Madagascar, Mauritania, Nigeria, Russian Federation, Somalia, Turkey, United Kingdom of Great Britain and Northern Ireland and United States of America.

(First plenary meeting, 21 May 2018)

WHA71(5) Adoption of the agenda

The Seventy-first World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 142nd session, with the deletion of six items and the exclusion of one supplementary item, and the transfer of one report from item 20 to item 12.

(Second plenary meeting, 21 May 2018)

WHA71(6) Verification of credentials

The Seventy-first World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cabo Verde; Cambodia; Cameroon; Canada; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czechia; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Eswatini; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Suriname; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

(Fifth plenary meeting, 23 May 2018 and
sixth plenary meeting, 25 May 2018)

WHA71(7) Election of Members entitled to designate a person to serve on the Executive Board

The Seventy-first World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: Australia, Chile, China, Djibouti, Finland, Gabon, Germany, Indonesia, Israel, Romania, Sudan, United States of America.

(Sixth plenary meeting, 25 May 2018)

WHA71(8) Addressing the global shortage of, and access to, medicines and vaccines[1]

The Seventy-first World Health Assembly, having considered the report on addressing the global shortage of, and access to, medicines and vaccines,[2] decided to request the Director-General:

(1) to elaborate a road map report, in consultation with Member States, outlining the programming of WHO's work on access to medicines and vaccines, including activities, actions and deliverables for the period 2019−2023;

(2) to submit this road map report to the Seventy-second World Health Assembly for its consideration in 2019, through the Executive Board at its 144th session.

(Sixth plenary meeting, 25 May 2018 –
Committee A, first report)

WHA71(9) Global strategy and plan of action on public health, innovation and intellectual property: overall programme review[1]

The Seventy-first World Health Assembly, having considered the report by the Director-General regarding the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property, [3] and its annex, decided:

(1) to urge Member States to implement, as appropriate and taking into account national contexts, the recommendations of the review panel[4] that are addressed to Member States and consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(2) to urge Member States also to further discuss the recommendations of the review panel not emanating from the global strategy and plan of action on public health, innovation and intellectual property;

(3) to request the Director-General to implement the recommendations addressed to the Secretariat as prioritized by the review panel, in an implementation plan, consistent with the global strategy and plan of action on public health, innovation and intellectual property;

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

[2] Document A71/12.

[3] Document A71/13.

[4] See Annex 5.

(4) to further request the Director-General to submit a report on progress made in implementing this decision to the Seventy-third World Health Assembly in 2020, through the Executive Board at its 146th session.

(Sixth plenary meeting, 25 May 2018 –
Committee A, first report)

WHA71(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan[1]

The Seventy-first World Health Assembly, taking note of the report by the Director-General requested in decision WHA70(12) 2017,[2] decided to request the Director-General:

(1) to report on progress in the implementation of the recommendations contained in the report by the Director-General, based on field monitoring, to the Seventy-second World Health Assembly;

(2) to provide support to the Palestinian health services, including through capacity-building programmes and the development of strategic plans for investments in specific treatment and diagnostic capacities locally;

(3) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;

(4) to continue providing the necessary technical assistance in order to meet the health needs of the Palestinian people, including prisoners and detainees, in cooperation with the efforts of the International Committee of the Red Cross, as well as the health needs of handicapped and injured people;

(5) to support the development of the health system in the occupied Palestinian territory, including east Jerusalem, by focusing on the development of human resources, in order to localize health services, decreasing referrals, reducing cost and maintaining strong primary health care with integrated complete appropriate health services; and

(6) to ensure the allocation of human and financial resources in order to achieve these objectives.

(Sixth plenary meeting, 25 May 2018 –
Committee B, first report)

[1] See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

[2] Document A71/27.

WHA71(11) Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits[1]

The Seventy-first World Health Assembly, having considered the report by the Director-General on progress to implement decision WHA70(10) (2017),[2] approved the recommendations contained therein at paragraph 19,[3] and requested that the final text of the analysis, requested under paragraph 8(b) of decision WHA70(10), be submitted to the Seventy-second World Health Assembly, through the Executive Board at its 144th session.

(Seventh plenary meeting, 26 May 2018 –
Committee B, third report)

WHA71(12) WHO programmatic and financial reports for 2016–2017, including audited financial statements for 2017

The Seventy-first World Health Assembly, having considered the WHO Results Report for the Programme budget 2016–2017 and the audited financial statements for 2017;[4] and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-first World Health Assembly,[5] decided to accept the WHO Results Report for the Programme budget 2016–2017 and the audited financial statements for 2017.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71(13) Report of the External Auditor

The Seventy-first World Health Assembly, having considered the report of the External Auditor to the Health Assembly;[6] and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-first World Health Assembly,[7] decided to accept the report of the External Auditor to the Health Assembly.

(Seventh plenary meeting, 26 May 2018
Committee B, second report)

WHA71(14) Appointment of representatives to the WHO Staff Pension Committee

The Seventy-first World Health Assembly nominated Dr Assad Hafeez of the delegation of Pakistan and Dr Alan Ludowyke of the delegation of Sri Lanka, as members for the remainder of their terms of office until May 2020.

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[1] See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

[2] Document A71/24.

[3] See Annex 6.

[4] Documents A71/28 and A71/29.

[5] Document A71/45.

[6] Document A71/32.

[7] Document A71/48.

The Health Assembly also nominated Dr Chieko Ikeda of the delegation of Japan and Dr Christoph Hauschild of the delegation of Germany as alternate members of the WHO Staff Pension Committee for three-year terms until May 2021.

(Seventh plenary meeting, 26 May 2018 –
Committee B, second report)

WHA71(15) Implementation of the International Health Regulations (2005): five-year global strategic plan to improve public health preparedness and response, 2018–2023[1]

The Seventy-first World Health Assembly, having considered the draft five-year global strategic plan to improve public health preparedness and response;[2] recalling decision WHA70(11) (2017), in which the Seventieth World Health Assembly took note of the report contained in document A70/16 on implementation of the International Health Regulations (2005): global implementation plan and requested the Director-General, inter alia, "to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 of document A70/16,[3] to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session"; recalling that Member States may use any voluntary monitoring and evaluation instruments, including those referenced in the five-year global strategic plan; and appreciating the contribution of Member States to the extensive consultative process to develop the draft five-year global strategic plan, including discussions at the sessions of all six regional committees in 2017, the web-based consultation conducted by the Secretariat between 19 September and 13 October 2017, and the consultation of Member States, through the Permanent Missions in Geneva, organized on 8 November 2017,

(1) decided:

(a) to welcome with appreciation the five-year global strategic plan to improve public health preparedness and response, noting that this does not create any legally binding obligations for Member States, and mindful of the legally binding nature of the International Health Regulations (2005) obligations;

(b) that States Parties and the Director-General shall continue to report annually to the Health Assembly on the implementation of the International Health Regulations (2005), using the self-assessment annual reporting tool;

(2) requested the Director-General:

(a) to provide the necessary financial and human resources to support the implementation of the five-year global strategic plan, and, as necessary, its adaptation to regional contexts and existing relevant frameworks;

(b) to continue to submit every year a single report to the Health Assembly on progress made in implementation of the International Health Regulations (2005), containing

[1] See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

[2] Document A71/8.

[3] See Annex 7.

information provided by States Parties and details of the Secretariat's activities, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005);

(c) to continue to provide support to Member States to build, maintain and strengthen core capacities under the International Health Regulations (2005).

(Seventh plenary meeting, 26 May 2018 –
Committee A, third report)

WHA71(16) Selection of the country in which the Seventy-second World Health Assembly would be held

The Seventy-first World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Seventy-second World Health Assembly would be held in Switzerland.

(Seventh plenary meeting, 26 May 2018)

ANNEX 8

Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Health Assembly

Resolution WHA71.2	Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018
A.	**Link to the programme budget**
1.	**Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.** **Programme area:** 2. Noncommunicable diseases **Outcome:** 2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors **Outputs:** 2.1.1. Development and implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated 2.1.2. Countries enabled to implement strategies to reduce modifiable risk factors for noncommunicable diseases (tobacco use, diet, physical inactivity and harmful use of alcohol), including the underlying social determinants 2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors, including in crises and emergencies
2.	**Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.** Not applicable.
3.	**Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.** Not applicable.
4.	**Estimated implementation time frame (in years or months) to achieve the resolution.** Eight years: all activities referred to in the resolution will be carried out during the bienniums 2020–2021, 2022–2023 and 2024–2025.
B.	**Resource implications for the Secretariat for implementation of the resolution**
1.	**Total resource requirements to implement the resolution, in US$ millions:** US$ 179 million (2018–2019).
2.a.	**Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:** US$ 179 million was planned for in the Programme budget 2018–2019: thus there are no additional requirements.
2.b.	**Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:** Not applicable.

3.	**Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:** Same as those in the Programme budget 2018–2019.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** Programme budget 2022–2023: same as those in the Programme budget 2018–2019. Programme budget 2024–2025: same as those in the Programme budget 2018–2019.
5.	**Resources available to fund the implementation of the resolution in the current biennium, in US$ millions** – **Resources available to fund the resolution in the current biennium:** US$ 82 million (46% of US$ 179 million). – **Remaining financing gap in the current biennium:** US$ 97 million (US$ 179 million minus US$ 82 million). – **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:** US$ 97 million.

Resolution WHA71.3	Preparation for a high-level meeting of the General Assembly on ending tuberculosis
A.	**Link to the programme budget**
1.	**Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.** **Programme area:** 1.2. Tuberculosis **Outcome:** 1.2. Universal access to quality tuberculosis care in line with the End TB Strategy **Output(s):** 1.2.1. Worldwide adaptation and implementation of the End TB Strategy and targets for tuberculosis prevention, care and control after 2015, as adopted in resolution WHA67.1 1.2.2. Updated policy guidelines and technical tools to support the implementation of the End TB Strategy and efforts to meet targets for tuberculosis prevention, care and control after 2015, covering the three pillars: (1) integrated, patient-centred care and prevention; (2) bold policies and supportive systems; and (3) intensified research and innovation
2.	**Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.** Not applicable.
3.	**Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.** Work called for within the resolution is already addressed in the Programme budget 2018–2019, including normative and strategic guidance, technical cooperation, monitoring and evaluation, research strategy and promotion efforts, as well as coordination efforts with other organizations of the United Nations system and other stakeholders. The expectation is that within the available budget, further stakeholder consultations can be held and technical cooperation undertaken to advance efforts including strengthened accountability of all stakeholders – governmental and non-State actors – at the country, regional and global levels.
4.	**Estimated implementation time frame (in years or months) to achieve the resolution.** Six years (2018–2023).

B.	Resource implications for the Secretariat for implementation of the resolution
1.	**Total resource requirements to implement the resolution, in US$ millions:** For 2018–2019: US$ 123.9 million, as in the Programme budget 2018–2019. For subsequent bienniums, the resource requirements will be further assessed and confirmed during the development of the relevant programme budget.
2.a.	**Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:** US$ 123.9 million (Programme budget 2018–2019 for tuberculosis).
2.b.	**Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:** No additional resource requirements are expected for the current biennium.
3.	**Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:** The resolution calls for acceleration of work on tuberculosis, compared with current effort, and will require, as a minimum, a 4% increase in resources in the Programme budget 2018–2019. The estimates will be further assessed and confirmed during the development of the programme budget for 2020–2021.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** It is expected that the acceleration of work on tuberculosis undertaken during 2020–2021 will be continued and will require, as a minimum, a 4% increase in resources in the Programme budget 2020–2021, to be reflected in future programme budget resource requirements.
5.	**Resources available to fund the implementation of the resolution in the current biennium, in US$ millions** – **Resources available to fund the resolution in the current biennium:** US$ 75 million. – **Remaining financing gap in the current biennium:** US$ 49 million. – **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:** US$ 30 million.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	25.0	11.3	0.95	5.3	5.75	3.3	7.4	59.0
	Activities	10.7	21.1	0.95	12.5	5.75	4.9	9.0	64.9
	Total	35.7	32.4	1.9	17.8	11.5	8.2	16.4	123.9
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	26.0	11.8	1.0	5.5	6.0	3.4	7.7	61.4
	Activities	11.1	21.9	1.0	13.0	6.0	5.1	9.4	67.5
	Total	37.1	33.7	2.0	18.5	12.0	8.5	17.1	128.9
2022–2023 resources to be planned	Staff	27.0	12.2	1.03	5.8	6.2	3.5	8.0	63.8[a]
	Activities	11.6	22.8	1.03	13.5	6.2	5.3	9.7	70.2[a]
	Total	38.6	35.0	2.06	19.3	12.4	8.8	17.7	134.0

[a] The row total does not add up due to rounding.

Resolution WHA71.4 Cholera prevention and control

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme area: E.1. Infectious hazard management

Outcome: E.1. All countries are equipped to mitigate risks from high-threat infectious hazards.

Output: E.1.1. Control strategies, plans and capacities developed for diseases such as cholera, viral haemorrhagic fever, meningitis and influenza and those due to vector-borne, emerging and re-emerging pathogens.

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

In line with the proposed resolution, additional activities for the biennium 2018–2019 include the reinforcement of the Global Task force on Cholera Control secretariat at WHO through the recruitment of additional staff, and increased capacity to support countries to scale up their ability to implement and monitor multisectoral cholera control plans through the organization of in-country workshops and recruitment of technical experts to be based in at least four cholera-affected countries.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

The resolution is aligned with the time frame of the Ending cholera: a global roadmap to 2030, with objectives set to reduce cholera deaths by 90% by 2030.

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

Estimated at US$ 121 million from 2018 to 2030, with an expected increase in staffing and activities in countries to provide support for the implementation of the entire road map in countries.

2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

US$ 7.93 million.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Zero.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

US$ 19.69 million for the biennium 2020–2021.

4. Estimated resource requirements in future programme budgets, in US$ millions:

US$ 10.43 annually, which reflects a 20% increase in staffing and activities requirements in the African Region, South-East Asia Region and Eastern Mediterranean Region, up to 2030.

5. Resources available to fund the implementation of the resolution in the current biennium, in US$ millions

– Resources available to fund the resolution in the current biennium:

US$ 4.10 million available under the cholera workplan 2018–2019 of the programme budget of the WHO Health Emergencies Programme.

– Remaining financing gap in the current biennium:

US$ 3.83 million.

– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:

Zero.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	3.87	1.00	0.25	0.20	NA	0.40	NA	5.72
	Activities	1.06	0.79	0.00	0.18	NA	0.18	NA	2.21
	Total	4.93	1.79	0.25	0.38	NA	0.58	NA	7.93
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	5.09	4.00	0.50	0.80	NA	1.20	NA	11.60
	Activities	1.70	3.56	0.53	0.57	NA	1.70	NA	8.09
	Total	6.79	7.56	1.03	1.37	NA	2.90	NA	19.69
Future bienniums resources to be planned	Staff	5.09	6.00	0.50	0.96	NA	1.44	NA	13.99
	Activities	1.93	2.68	0.39	0.68	NA	1.19	NA	6.87
	Total	7.02	8.68	0.89	1.64	NA	2.63	NA	20.86

NA: not applicable.

Resolution WHA71.5 Addressing the burden of snakebite envenoming

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme areas:

1.4. Neglected tropical diseases

4.3. Access to medicines and other health technologies and strengthening regulatory capacity

Outcome(s):

1.4. Increased and sustained access to neglected tropical disease control interventions

4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies

Output(s):

1.4.2. Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support

4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools

4.3.3. Improved quality and safety of medicines and other health technologies through norms, standards and guidelines, strengthening of regulatory systems, and prequalification

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018-2019.

Although they were not specified during the process of preparing the Programme budget 2018–2019, the deliverables planned will contribute to the outputs detailed above. They are set out below.

- Accelerate global efforts and coordination for the control of snakebite envenoming, ensuring the quality, efficacy and safety of antivenoms and other treatments, and the prioritization of high impact interventions;
- Continue to offer technical support to institutions working on research into snakebite envenoming, including WHO collaborating centres, in support of improved, evidence-based disease control efforts;
- Foster international efforts aimed at strengthening the production, regulation and control of quality, safety and efficacy of snake antivenom immunoglobulins and improving the availability, accessibility and affordability of safe and effective antivenoms for all;
- Support Member States to strengthen capacities for improving awareness and prevention and access to treatment, and for reducing and controlling snakebite envenoming;
- Foster technical cooperation among countries as a means of strengthening surveillance, treatment and rehabilitation services;
- Cooperate, as appropriate and in accordance with their respective mandates, with international agencies, nongovernmental organizations, foundations and research institutions, to directly support countries in which the disease is prevalent, upon the request of such countries, in order to strengthen snakebite management activities.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

No end-date is presently foreseen for this resolution, with implementation efforts forming part of the ongoing work concerned with the control and elimination of neglected tropical diseases. The financial information presented here concerns the six-year period July 2018 to−2023.

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

US$ 29.66 million for the first six years.

2.a Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

Zero.

2.b Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

US$ 6.33 million.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

US$ 10.63 million.

4. Estimated resource requirements in future programme budgets, in US$ millions:

US$ 12.70 million per biennium, plus cost of indexation against inflation.

5. Resources available to fund the implementation of the resolution in the current biennium, in US$ millions

– **Resources available to fund the resolution in the current biennium:**

Zero.

– **Remaining financing gap in the current biennium:**

US$ 6.33 million.

– **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:**

None at present. Mobilization of funds will be linked to the primary outcome of the deliverables in the biennium 2018−2019. The development of the snakebite envenoming roadmap and the organization of the associated stakeholder meeting are expected to mobilize donor voluntary contributions amounting to at least 50% of the biennium budget.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2018–2019 additional resources	Staff	1.32	0.15	0.13	0.12	0.07	0.12	0.14	2.05
	Activities	2.53	0.55	0.23	0.31	0.16	0.24	0.26	4.28
	Total	3.85	0.70	0.36	0.43	0.23	0.36	0.40	6.33
2020–2021 resources to be planned	Staff	1.98	1.04	0.69	0.83	0.33	0.63	0.70	6.20
	Activities	2.85	0.47	0.21	0.28	0.16	0.22	0.24	4.43
	Total	4.83	1.51	0.90	1.11	0.49	0.85	0.94	10.63
Future bienniums resources to be planned	Staff	3.26	1.08	0.96	0.86	0.50	0.87	0.98	8.51
	Activities	2.55	0.49	0.22	0.29	0.16	0.23	0.25	4.19
	Total	5.81	1.57	1.18	1.15	0.66	1.10	1.23	12.70

Resolution WHA71.6 WHO global action plan on physical activity 2018–2030

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme area: 2.1. Noncommunicable diseases

Outcome: 2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors

Outputs:

2.1.1. Development and implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated

2.1.2. Countries enabled to implement strategies to reduce modifiable risk factors for noncommunicable diseases (tobacco use, diet, physical inactivity and harmful use of alcohol), including the underlying social determinants

2.1.4. Monitoring framework implemented to report on the progress made on the commitments contained in the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

None.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

Eight years.

B.	**Resource implications for the Secretariat for implementation of the resolution**
1.	**Total resource requirements to implement the resolution, in US$ millions:** US$ 30.3 million.
2.a	**Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:** US$ 9.4 million.
2.b	**Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:** Zero.
3.	**Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:** US$ 8.1 million.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** 2022–2023: US$ 6.4 million. 2024–2025: US$ 6.4 million.
5.	**Resources available to fund the implementation of the resolution in the current biennium, in US$ millions** – **Resources available to fund the resolution in the current biennium:** Zero. – **Remaining financing gap in the current biennium:** US$ 9.4 million. – **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:** Zero.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	1.2	0.8	0.8	0.6	0.7	0.6	0.7	5.4
	Activities	2.8	0.2	0.2	0.2	0.2	0.2	0.2	4.0
	Total	4.0	1.0	1.0	0.8	0.9	0.8	0.9	9.4
2018–2019 additional resources	Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2020–2021 resources to be planned	Staff	1.2	0.8	0.8	0.6	0.7	0.6	0.7	5.4
	Activities	1.5	0.2	0.2	0.2	0.2	0.2	0.2	2.7
	Total	2.7	1.0	1.0	0.8	0.9	0.8	0.9	8.1
Future bienniums resources to be planned	Staff	2.4	1.6	1.6	1.2	1.4	1.2	1.4	10.8
	Activities	0.8	0.2	0.2	0.2	0.2	0.2	0.2	2.0
	Total	3.2	1.8	1.8	1.4	1.6	1.4	1.6	12.8

Resolution WHA71.7 Digital health

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme areas:

2.1. Noncommunicable diseases

3.1. Reproductive, maternal, newborn and child health

4.4. Health systems, information and evidence

Outcomes:

2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors

3.1. Increased access to interventions for improving health of women, newborns, children and adolescents

4.4. All countries having well-functioning health information, eHealth, research, ethics and knowledge management systems to support national health priorities

Outputs:

2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors, including in crises and emergencies

2.1.5. Enhanced coordination of activities, multistakeholder engagement and action across sectors in collaborative work with relevant United Nations system organizations, other intergovernmental organizations and non-State actors, to support governments to meet their commitments on the prevention and control of noncommunicable diseases

3.1.6. Research undertaken and research capacity strengthened for sexual and reproductive and maternal health through the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP)

4.4.2. Countries enabled to plan, develop and implement an eHealth strategy

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

48 months, pending further review.

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

US$ 32.2 million.

2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

US$ 16.1 million.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Zero.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

US$ 16.1 million.

4. Estimated resource requirements in future programme budgets, in US$ millions:

Not applicable (pending further review).

5. Resources available to fund the implementation of the resolution in the current biennium, in US$ millions

– Resources available to fund the resolution in the current biennium:

US$ 11.5 million.

– Remaining financing gap in the current biennium:

US$ 4.6 million.

– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:

Fundraising is ongoing.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	3.60	0.50	0.50	0.50	0.50	0.50	0.50	6.60
	Activities	5.00	0.75	0.75	0.75	0.75	0.75	0.75	9.50
	Total	8.60	1.25	1.25	1.25	1.25	1.25	1.25	16.10
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	3.60	0.50	0.50	0.50	0.50	0.50	0.50	6.60
	Activities	5.00	0.75	0.75	0.75	0.75	0.75	0.75	9.50
	Total	8.60	1.25	1.25	1.25	1.25	1.25	1.25	16.10

Resolution WHA71.8 Improving access to assistive technology

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme area: 2.4. Disabilities and rehabilitation

Outcome: 2.4. Increased access to comprehensive eye care, hearing care and rehabilitation services

Output: 2.4.1. Implementation of the WHO global disability action plan 2014–2021: better health for all people with disability, in accordance with national priorities

Programme area: 3.2. Ageing and health

Outcome: 3.2. Increased proportion of people who are able to live a long and healthy life

Output: 3.2.1. Countries enabled to develop policies, strategies and capacity to foster healthy ageing across the life-course

Programme area: 4.3. Access to medicines and other health technologies, and strengthening regulatory capacity

Outcome: 4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies

Output: 4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools

2.	**Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.** Not applicable.
3.	**Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.** No additional deliverables are foreseen, but existing deliverables that support establishing regional or subregional assistive technology manufacturing, procurement and supply networks (notably the production of the first draft of the World report on assistive technology) are to be scaled up and strengthened
4.	**Estimated implementation time frame (in years or months) to achieve the resolution.** The implementation time frame is currently planned up to 2030. Work may continue beyond this date as needed.
B.	**Resource implications for the Secretariat for implementation of the resolution**
1.	**Total resource requirements to implement the resolution, in US$ millions:** US$ 32.5 million until 2030.
2.a	**Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:** US$ 2.45 million.
2.b	**Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:** US$ 2.55 million.
3.	**Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:** US$ 5.0 million per biennium.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** US$ 5.0 million per biennium.
5.	**Resources available to fund the implementation of the resolution in the current biennium, in US$ millions**
–	**Resources available to fund the resolution in the current biennium:** US$ 2.45 million.
–	**Remaining financing gap in the current biennium:** US$ 2.55 million.
–	**Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:** US$ 15.0 million until 2030.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	1.60	0.00	0.00	0.00	0.00	0.00	0.00	1.60
	Activity	0.20	0.15	0.05	0.15	0.05	0.20	0.05	0.85
	Total	1.80	0.15	0.05	0.15	0.05	0.20	0.05	2.45
2018–2019 additional resources	Staff	0.25	0.10	0.05	0.10	0.05	0.10	0.05	0.70
	Activity	0.60	0.20	0.10	0.20	0.25	0.25	0.25	1.85
	Total	0.85	0.30	0.15	0.30	0.30	0.35	0.30	2.55
2020–2021 resources to be planned	Staff	1.85	0.10	0.10	0.10	0.05	0.10	0.05	2.35
	Activity	0.65	0.40	0.20	0.40	0.25	0.50	0.25	2.65
	Total	2.50	0.50	0.30	0.50	0.30	0.60	0.30	5.00
Future bienniums resources to be planned	Staff	1.85	0.10	0.10	0.10	0.05	0.10	0.05	2.35
	Activity	0.65	0.40	0.20	0.40	0.25	0.50	0.25	2.65
	Total	2.50	0.50	0.30	0.50	0.30	0.60	0.30	5.00

Resolution WHA71.9 Infant and young child feeding

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme area: 2.5. Nutrition

Outcome: 2.5. Reduced nutritional risk for improved health and well-being

Output(s): 2.5.1. Countries enabled to develop and monitor implementation of action plans to tackle malnutrition in all its forms and achieve the global nutrition targets 2025 and the nutrition components of the Sustainable Development Goals

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

Four years.

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

US$ 5.1 million.

2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

US$ 1.7 million.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Zero.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

US$ 3.4 million.

4. Estimated resource requirements in future programme budgets, in US$ millions:

Zero.

5. Resources available to fund the implementation of the resolution in the current biennium, in US$ millions

– **Resources available to fund the resolution in the current biennium:**

US$ 1.3 million.

– **Remaining financing gap in the current biennium:**

US$ 0.4 million.

– **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:**

US$ 0.1 million.

Table. Breakdown of estimated resource requirements (in US$)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	315 500	58 400	52 800	46 000	52 300	59 700	56 400	641 100
	Activities	640 000	100 000	70 000	50 000	50 000	80 000	80 000	1 070 000
	Total	955 500	158 400	122 800	96 000	102 300	139 700	136 400	1 711 100
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	526 500	142 200	129 600	110 000	127 700	126 700	128 800	1 291 500
	Activities	640 000	250 000	250 000	250 000	250 000	250 000	250 000	2 140 000
	Total	1 166 500	392 200	379 600	360 000	377 700	376 700	378 800	3 431 500

Resolution WHA71.11 Deputy Directors-General

Resolution WHA71.12 Salaries of staff in ungraded positions and of the Director-General

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme area: 6.4. Management and administration

Outcome: 6.4. Effective and efficient management and administration established across the Organization

Output: 6.4.2. Effective and efficient human resources management and coordination in place

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

With respect to **draft resolution 1**, the related amendments to the Staff Rules will enter into force:

(a) with effect from 1 January 2018 concerning the remuneration of staff in the professional and higher categories; and

(b) with effect from 1 February 2018 concerning definitions, education grants, settling-in grants, repatriation grants, mobility, special leave, leave without pay, resignations, administrative reviews and the Global Board of Appeal.

With respect to **draft resolution 2**, the related amendments to the Staff Regulations to reflect the current structure of the Organization will enter into force with effect from 1 January 2018.

With respect to **draft resolution 3**, the related modifications to salaries of staff in ungraded posts and of the Director-General will enter into force with effect from 1 January 2018.

There is no defined end date for implementation.

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

Resource requirements are already included within what is planned under the Programme budget 2018–2019.

With respect to draft resolution 1(1) and draft resolution 3 regarding modifications to staff salaries, payroll costs are always subject to some variability due to post adjustment, exchange rates, staff mix in terms of dependency and education grant entitlements among other factors, so these additional costs will be absorbed within the overall payroll budget fluctuations.

Draft resolution 1(2) does not have any resource requirements.

With respect to draft resolution 2, the amendments to the Staff Regulations do not in themselves have any resource requirements. However, additional positions within the current structure of the Organization are to be funded under current budget allocations.

2.a Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

Not applicable.

2.b Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Not applicable.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

Not applicable.

4. Estimated resource requirements in future programme budgets, in US$ millions:

Not applicable.

5. Resources available to fund the implementation of the resolution in the current biennium, in US$ millions

– **Resources available to fund the resolution in the current biennium:**

Not applicable.

– **Remaining financing gap in the current biennium:**

Not applicable.

– **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:**

Not applicable.

Resolution WHA71.13 Reform of the global internship programme

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme area: 6.4. Management and administration

Outcome: 6.4. Effective and efficient management and administration consistently established across the Organization

Outputs:

6.4.2. Effective and efficient human resources management and coordination in place

6.4.1. Sound financial practices managed through an adequate control framework

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

Immediate implementation in order to reach the target of 50% of accepted interns on the programme to originate from least developed countries and middle-income countries by 2022, and then maintain the level.

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

US$ 11.32 million.

2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

US$ 1.81 million.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Zero.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

US$ 4.43 million.

4. Estimated resource requirements in future programme budgets, in US$ millions:

US$ 5.08 million.

5. Resources available to fund the implementation of the resolution in the current biennium, in US$ millions

– Resources available to fund the resolution in the current biennium:

US$ 0.57 million.

– Remaining financing gap in the current biennium:

US$ 1.24 million.

– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:

US$ 0.2 million and possibilities for technical units to cover stipends from their activities funds (not necessarily under Category 6).

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	0.375	0	NA	0	0	0	0	0.375
	Activities	1.122	0.036	NA	0.012	0.143	0.043	0.081	1.437
	Total	1.497	0.036	NA	0.012	0.143	0.043	0.081	1.812
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	0.500	0	NA	0	0	0	0	0.500
	Activities	2.855	0.124	NA	0.042	0.487	0.145	0.274	3.927
	Total	3.355	0.124	NA	0.042	0.487	0.145	0.274	4.427
Future bienniums resources to be planned	Staff	0.530	0	NA	0	0	0	0	0.530
	Activities	3.289	0.145	NA	0.049	0.574	0.171	0.323	4.551
	Total	3.819	0.145	NA	0.049	0.574	0.171	0.323	5.081

Resolution WHA71.14 Rheumatic fever and rheumatic heart disease

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Communicable diseases

Outcome: 1.4. Increased and sustained access to neglected tropical disease control interventions.

Noncommunicable diseases

Outcome: 2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors.

Promoting health through the life course

Outcome: 3.1. Increased access to interventions for improving health of women, newborns, children and adolescents.

Outcome: 3.5. Reduced environmental threats to health.

Health systems

Outcome: 4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies.

Output(s):

- Output 1.4.2. Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support.
- Output 2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors, including in crises and emergencies.
- Output 3.1.1. Countries enabled to improve maternal health through further expansion of access to, and improvement in the quality of, effective interventions for ending preventable maternal deaths from pre-pregnancy to postpartum and perinatal deaths (stillbirths and early neonatal deaths), with a particular focus on the 24-hour period around childbirth.
- Output 3.5.2. Norms and standards established and guidelines developed for environmental and occupational health risks and benefits associated with, for example, air and noise pollution, chemicals, waste, water and sanitation, radiation, and climate change and technical support provided at the regional and country levels for their implementation.
- Output 4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools.

2. Short justification for considering the draft resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

A process to set appropriate targets and develop a comprehensive plan of action will be developed by the Secretariat during the biennium 2018–2019. Other activities referred to in the resolution will be carried out during the bienniums 2020–2021, 2022–2023 and 2024–2025.

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

US$ 13.75 million.

2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

US$ 0.05 million was planned and the requirements are US$ 0.6 million.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Not applicable.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
   – staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US$ 0.45 million.
2. To provide support to Member States in implementing national programmes on rheumatic heart disease and strengthening health systems through: improved disease surveillance; increased availability and training of the community and primary health care workforces; and ensuring reliable access to affordable prevention and treatment tools:
   – updating technical guidelines on primary and secondary prevention of rheumatic heart disease: US$ 0.50 million
   – providing country technical support: US$ 3.50 million.

Total: US$ 4.45 million

4. Estimated resource requirements in future programme budgets, in US$ millions:

Biennium 2022–2023

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
   – staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US$ 0.45 million
   – activities: US$ 0.40 million.
2. To provide support to Member States in implementing national programmes on rheumatic heart disease and strengthening health systems through: improved disease surveillance; increased availability and training of the community and primary health care workforces; and ensuring reliable access to affordable prevention and treatment tools:
   – providing country technical support: US$ 3.50 million.

Total: US$ 4.35 million

Biennium 2024–2025

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
   – staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US$ 0.45 million
   – activities: US$ 0.40 million.
2. To provide support to Member States in implementing national programmes on rheumatic heart disease and strengthening health systems through: improved disease surveillance; increased availability and training of the community and primary health care workforces; and ensuring reliable access to affordable prevention and treatment tools:
   – providing country technical support: US$ 3.50 million.

Total: US$ 4.35 million

The total additional costs for these two bienniums (US$ 8.70 million) are to be planned within the respective proposed programme budgets.

5. Resources available to fund the implementation of the resolution in the current biennium, in US$ millions

– Resources available to fund the resolution in the current biennium:

US$ 0.05 million.

– Remaining financing gap in the current biennium:

US$ 0.55 million.

– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:

US$ 0.55 million.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	0.30	–	–	–	–	–	–	0.30
	Activities	0.20	0.10	–	–	–	–	–	0.30
	Total	0.50	0.10	–	–	–	–	–	0.60
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	0.45	0.90	–	–	–	–	0.70	2.05
	Activities	0.50	1.00	–	0.40	–	–	0.50	2.40
	Total	0.95	1.90	–	0.40	–	–	1.20	4.45
Future bienniums 2022–2023 resources to be planned	Staff	0.45	0.90	–	–	–	–	0.70	2.05
	Activities	0.40	1.00	–	0.40	–	–	0.50	2.30
	Total	0.85	1.90	–	0.40	–	–	1.20	4.35
Future bienniums 2024–2025 resources to be planned	Staff	0.45	0.90	–	–	–	–	0.70	2.05
	Activities	0.40	1.00	–	0.40	–	–	0.50	2.30
	Total	0.85	1.90	–	0.40	–	–	1.20	4.35

Resolution WHA71.15 Multilingualism: respect for equality among the official languages

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme areas:

4.4. Health systems, information and evidence

6.1. Leadership and governance

6.5. Strategic communications

Outcomes:

4.4. All countries having well-functioning health information, eHealth, research, ethics and knowledge management systems to support national health priorities

6.1. Greater coherence in global health, with WHO taking the lead in enabling the different actors to play an active and effective role in contributing to the health of all people

6.5. Improved public and stakeholders' understanding of the work of WHO

Outputs:

4.4.3. Knowledge management policies, tools, networks and resources developed and used by WHO and countries to strengthen their capacity to generate, share and apply knowledge

6.1.3. WHO governance strengthened with effective oversight of governing body sessions and efficient, aligned agendas

6.5.1. Accurate and timely health information accessible through a platform for effective communication and related practices

2.	**Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.** Not applicable.
3.	**Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.** Russian-language translations, printing and distribution of technical publications; website and journal content, digitization, citation analyses and glossary of terms.
4.	**Estimated implementation time frame (in years or months) to achieve the resolution.** Four years, for the time-limited actions in the resolution. Ongoing corporate language services will require continuous implementation.
B.	**Resource implications for the Secretariat for implementation of the resolution**
1.	**Total resource requirements to implement the resolution, in US$ millions:** US$ 83.94 million for the bienniums 2018–2019 and 2020–2021.
2.a.	**Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:** US$ 41.60 million.
2.b.	**Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:** Not applicable.
3.	**Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:** US$ 42.34 million.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** US$ 42.34 million.
5.	**Resources available to fund the implementation of the resolution in the current biennium, in US$ millions** **– Resources available to fund the resolution in the current biennium:** US$ 40.00 million. **– Remaining financing gap in the current biennium:** US$ 1.60 million. **– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:** Zero.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	19.73	2.60	3.10	–	3.25	1.43	0.14	30.25
	Activities	8.26	0.03[b]	2.00	–	0.34[b]	0.72	–	11.35
	Total	27.99	2.63	5.10	–	3.59	2.15	0.14	41.60
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	20.00	2.60	3.10	–	3.25	1.50	0.14	30.59
	Activities	8.00	0.50	2.00	–	0.50	0.75	–	11.75
	Total	28.00	3.10	5.10	–	3.75	2.25	0.14	42.34
Future bienniums resources to be planned	Staff	20.00	2.60	3.10	–	3.25	1.50	0.14	30.59
	Activities	8.00	0.50	2.00	–	0.50	0.75	–	11.75
	Total	28.00	3.10	5.10	–	3.75	2.25	0.14	42.34

[a] Preliminary costing, which does not necessarily include the full cost of publishing in official languages in all major offices or the full cost from a human resources perspective.

[b] Activity cost for language service unit only.

Resolution WHA71.16 Poliomyelitis – containment of polioviruses

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this resolution will contribute.

Programme area: Polio eradication.

Outcome: No case of paralysis due to wild or type-2 vaccine-related poliovirus globally.

Output(s): All four.

2. Short justification for considering the resolution, if there is no link to the results as indicated in the Programme budget 2018–2019.

Full implementation of the resolution would support achievement of a lasting polio-free world, based on the interruption of transmission of wild and vaccine-derived polioviruses and secure containment of any poliovirus in a laboratory setting.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the resolution.

Estimated four years to global certification, followed by additional years through the post-certification strategy (submitted to the Seventy-first World Health Assembly).

B. Resource implications for the Secretariat for implementation of the resolution

1. Total resource requirements to implement the resolution, in US$ millions:

There is no incremental cost – for either activities or staffing – associated with the resolution, as the related costs had already been foreseen and budgeted in the Polio Eradication and Endgame Strategic Plan 2013–2018 and will be included as part of the post-certification strategy.

2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

Total: US$ nil (staff: US$ nil; activities: US$ nil) as per section B.1 above.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Not applicable as per section B.1 above.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

Not applicable as per section B.1 above.

4. Estimated resource requirements in future programme budgets, in US$ millions:

Not applicable as per section B.1 above.

5. Resources available to fund the implementation of the resolution in the current biennium, in US$ millions

– **Resources available to fund the resolution in the current biennium:**

Not applicable as per section B.1 above.

– **Remaining financing gap in the current biennium:**

Not applicable as per section B.1 above.

– **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:**

Not applicable as per section B.1 above.

Decision WHA71(8) Addressing the global shortage of, and access to, medicines and vaccines

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.

Programme area: 4.3. Access to medicines and other health technologies, and strengthening regulatory capacity

Outcome: 4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies

Output: 4.3.1. Access to and use of essential medicines and other health technologies improved through global guidance and the development and implementation of national policies, strategies and tools

Output: 4.3.3. Improved quality and safety of medicines and other health technologies through norms, standards and guidelines, strengthening of regulatory systems, and prequalification

2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the decision.

18 months.

B. Resource implications for the Secretariat for implementation of the decision

1. Total resource requirements to implement the decision, in US$ millions:

US$ 0.6 million.

2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

US$ 0.6 million.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Not applicable.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

Not applicable.

4. Estimated resource requirements in future programme budgets, in US$ millions:

Not applicable.

5. Resources available to fund the implementation of the decision in the current biennium, in US$ millions

– Resources available to fund the decision in the current biennium:

US$ 0.6 million.

– Remaining financing gap in the current biennium:

Zero.

– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:

Zero.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.4
	Activities	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.2
	Total	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.6

Decision WHA71(9)	Global strategy and plan of action on public health, innovation and intellectual property: overall programme review
A.	**Link to the programme budget**
1.	**Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.** **Programme area:** 4.3. Access to medicines and other health technologies and strengthening regulatory capacity **Outcome:** 4.3. Improved access to and rational use of safe, efficacious and affordable quality medicines and other health technologies **Output:** 4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property
2.	**Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.** Not applicable.
3.	**Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.** Not applicable.
4.	**Estimated implementation time frame (in years or months) to achieve the decision.** Five years (2018 to 2022).
B.	**Resource implications for the Secretariat for implementation of the decision**
1.	**Total resource requirements to implement the decision, in US$ millions:** US$ 31.50 million for the period 2018 to 2022.
2.a.	**Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:** US$ 10.80 million.
2.b.	**Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:** Zero.
3.	**Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:** US$ 13.60 million.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** US$ 7.10 million.

5. Resources available to fund the implementation of the decision in the current biennium, in US$ millions

– **Resources available to fund the decision in the current biennium:**
US$ 3.00 million.

– **Remaining financing gap in the current biennium:**
US$ 7.80 million.

– **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:**
Discussions are ongoing with Member States for mobilizing additional resources.

Decision WHA71(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.

Programme areas:

6.1. Leadership and governance

6.4. Management and administration

Outbreak and crisis response

Outcomes:

6.1. Greater coherence in global health, with WHO taking the lead in enabling the different actors to play an active and effective role in contributing to the health of all people

6.4. Effective and efficient management and administration consistently established across the Organization

Outbreak and crisis response

Outputs:

6.1.1. Effective WHO leadership and management and improved capacities of the WHO Secretariat and Member States to promote, align, coordinate and operationalize efforts to achieve the Sustainable Development Goals

6.1.2. Effective engagement with other United Nations agencies and non-State actors in building a common health agenda that responds to Member States' priorities

6.4.1. Sound financial practices managed through an adequate control framework

6.4.2. Effective and efficient human resources management and coordination in place

6.4.3. Efficient and effective computing infrastructure, corporate and health-related systems and applications

6.4.4. Provision of operational and logistics support, procurement, infrastructure maintenance and asset management, and of a secure environment for WHO staff and property

Outbreak and crisis response

2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the decision.

One year: June 2018–May 2019.

B.	**Resource implications for the Secretariat for implementation of the decision**
1.	**Total resource requirements to implement the decision, in US$ millions:** US$ 10.11 million (staff: US$ 3.86 million; activities: US$ 6.25 million).
2.a.	**Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:** Total: US$ 8.25 million (staff: US$ 3.75 million; activities: US$ 4.50 million) to be accommodated within the existing programme budget envelope.
2.b.	**Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:** Total: US$ 1.86 million.
3.	**Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:** Not applicable.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** Not applicable.
5.	**Resources available to fund the implementation of the decision in the current biennium, in US$ millions** **– Resources available to fund the decision in the current biennium:** US$ 6 million. **– Remaining financing gap in the current biennium:** Funding (US$ 4.11 million) will continue to be sought through voluntary contributions, including the strategic response plan for the occupied Palestinian territory, including east Jerusalem. **– Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:** Not applicable.

Decision WHA71(11)	Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits
A.	**Link to the programme budget**
1.	**Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.** **Programme area: E.1** Infectious hazard management; **E.2** Country health emergency preparedness and the International Health Regulations (2005) **Outcome: E.1** – All countries are equipped to mitigate risks from high-threat infectious hazards; **E.2** All countries assess and address critical gaps in preparedness for health emergencies, including gaps in core capacities under the International Health Regulations (2005) and in capacities for all-hazard health emergency risk management. **Output(s): E.1.1** – Control strategies, plans and capacities developed for diseases such as cholera, viral haemorrhagic fevers, meningitis, influenza and those due to vector-borne, emerging and re-emerging pathogens; and **E.1.2** – Global expert networks and innovative mechanisms developed to manage new and evolving high-threat infectious hazards (such as for clinical management, laboratories, social science, and data modelling); **E.2.2** – Critical core capacities for health emergency preparedness, disaster risk management and the International Health Regulations (2005) strengthened in all countries.

2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.

During the Seventieth World Health Assembly, Member States considered the report of the 2016 PIP Framework Review Group as required under PIP Framework section 7.4.2. Further to such consideration, the Health Assembly adopted decision WHA70(10) which requests the Director-General, inter alia, to report to the Seventy-first World Health Assembly on progress in implementing the decision and to make recommendations for further action.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

The Secretariat aims to implement all actions within its mandate by the Seventy-second World Health Assembly. Certain elements, such as the analysis requested in paragraph 8(b) of decision WHA70(10), will be submitted as drafts in order to collect Member States' views before being finalized for submission to the Seventy-third World Health Assembly, through the Executive Board at its 146th session.

4. Estimated implementation time frame (in years or months) to achieve the decision.

Up to 18 months.

B. Resource implications for the Secretariat for implementation of the decision

1. Total resource requirements to implement the decision, in US$ millions:

In 2017, as indicated for decision WHA70(10), total resource requirements for implementation of the recommendations of the 2016 PIP Framework Review Group were US$ 2.91 million for implementation in 2017 and 2018–2019. For the current biennium the total resource requirements are US$ 1.36 million.

2.a. Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:

Total estimated resource requirements already allocated in Programme budget 2018–2019 are US$ 1.36 million. Because the PIP Framework sits outside the Programme budget, implementing the decision can be accommodated without increasing the budget space.

2.b. Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:

Nil.

3. Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:

None at this time.

4. Estimated resource requirements in future programme budgets, in US$ millions:

N/A

5. Resources available to fund the implementation of the decision in the current biennium, in US$ millions

– Resources available to fund the decision in the current biennium:

US$ 0.690 million available and funded to cover 2018 costs under PIP Framework secretariat workplan 2018–2019.

– Remaining financing gap in the current biennium:

US$ 0.666 million.

– **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:**

The main means for closing the gap is collection of the full annual Partnership Contributions from industry manufacturers. Other sources will include funding from other donors.

Table. Breakdown of estimated resource requirements (in US$)

Biennium	Costs	Headquarters	Region						Total
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	480 000	N/A	N/A	N/A	N/A	N/A	N/A	
	Activities	876 000	N/A	N/A	N/A	N/A	N/A	N/A	
	Total	1 356 000	N/A	N/A	N/A	N/A	N/A	N/A	
2018–2019 additional resources	Staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Activities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
2020–2021 resources to be planned	Staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Activities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Future bienniums resources to be planned	Staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Activities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Total	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

Decision WHA71(15) Implementation of International Health Regulations (2005): five-year global strategic plan to improve public health preparedness and response, 2018–2023

A. Link to the programme budget

1. Programme area, outcome and output(s) in the Programme budget 2018–2019 to which this decision will contribute.

Programme area: E.2. Country health emergency preparedness and the International Health Regulations (2005)

Outcome: E.2. All countries assess and address critical gaps in preparedness for health emergencies, including in core capacities under the International Health Regulations (2005) and in capacities for all-hazard health emergency risk management

Output: E.2.4. Secretariat support provided for implementation of the International Health Regulations (2005)

The implementation of the five-year global strategic plan requires activities across the WHO Health Emergencies Programme, the cost of which is included in the overall programme budget of the Health Emergencies Programme. The cost of the implementation of the decision is understood as only the cost of the Secretariat's support for coordination of implementation, monitoring and reporting on the five-year global strategic plan.

2. Short justification for considering the decision, if there is no link to the results as indicated in the Programme budget 2018–2019.

Not applicable.

3. Brief description of any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the Programme budget 2018–2019.

Not applicable.

4. Estimated implementation time frame (in years or months) to achieve the decision.

Five years.

B.	**Resource implications for the Secretariat for implementation of the decision**
1.	**Total resource requirements to implement the decision, in US$ millions:** US$ 10.65 million.
2.a	**Estimated resource requirements already planned for in the Programme budget 2018–2019, in US$ millions:** US$ 2.40 million.
2.b	**Estimated resource requirements in addition to those already planned for in the Programme budget 2018–2019, in US$ millions:** None.
3.	**Estimated resource requirements in the Programme budget 2020–2021, in US$ millions:** US$ 3.94 million.
4.	**Estimated resource requirements in future programme budgets, in US$ millions:** US$ 4.31 million for 2022–2023.
5.	**Resources available to fund the implementation of the decision in the current biennium, in US$ millions** – **Resources available to fund the decision in the current biennium:** None. – **Remaining financing gap in the current biennium:** US$ 2.40 million. – **Estimated resources, foreseen but not yet available, which would help to close the financing gap in the current biennium:** The allocation of assessed contributions is not yet known.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Headquarters	Region						Total[a]
			Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	
2018–2019 resources already planned	Staff	0.61	0.25	0.27	0.20	0.23	0.20	0.25	2.00
	Activities	0.10	0.05	0.05	0.05	0.05	0.05	0.05	0.40
	Total	0.71	0.30	0.32	0.25	0.28	0.25	0.30	2.40
2018–2019 additional resources	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2020–2021 resources to be planned	Staff	0.63	0.52	0.56	0.42	0.48	0.41	0.51	3.52
	Activities	0.10	0.05	0.05	0.05	0.05	0.05	0.05	0.42
	Total	0.73	0.57	0.61	0.47	0.53	0.46	0.56	3.94
Future bienniums resources to be planned	Staff	0.65	0.54	0.58	0.44	0.50	0.43	0.53	3.66
	Activities	0.16	0.08	0.08	0.08	0.08	0.08	0.08	0.65
	Total[a]	0.82	0.62	0.66	0.52	0.58	0.51	0.61	4.31

[a] Some totals do not add up due to rounding.